No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

LAURENCE H. TRIBE*
Hauser Hall 420
1575 Massachusetts Avenue
Cambridge, Massachusetts 02138
(617) 495-4621

CARLA A. KERR
REID A. MUOIO
Hughes, Hubbard & Reed
1 Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Respondents

* Counsel of Record

DENNIS C. VACCO
Attorney General of the
State of New York
Attorney for Petitioners
The Capitol–2d Floor
Albany, New York 12224
(518) 474-8101

BARBARA GOTT BILLET*
Solicitor General

DANIEL SMIRLOCK
Assistant Attorney General

MICHAEL S. POPKIN
Assistant Attorney General

LUCIA M. VALENTE
Chief Special Counsel
Of Counsel

* Counsel of Record

PETITION FOR CERTIORARI FILED MAY 16, 1996
CERTIORARI GRANTED OCTOBER 1, 1996

TABLE OF CONTENTS

PAGE

PAGE

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Case No. 94 Civ. 5321 (TPG)

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

7/20/94	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120 RECEIPT # 220299 (sc) [Entry date 07/25/94]
7/20/94	2	Rule 9 certificate filed by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth (sc) [Entry date 07/25/94]

7/20/94	3	Case Information Statement Addendum and Case Designation to a Magistrate Judge filed. Purs. to statement, it is suggested that the case be classified as expedited. Case is designated to Magistrate Judge Bernikow. (sc) [Entry date 07/25/94]
8/22/94	4	STIPULATION and ORDER, reset answer due for 8/22/94 for C. Oliver Koppell (signed by Chief Judge Thomas P. Griesa). (gb) [Entry date 08/23/94]
8/23/94	5	ANSWER to Complaint by G. Oliver Koppell (Attorney Susan L. Watson), by attorney Susan L. Watson for defendant G. Oliver Koppell. (kg) [Entry date 08/25/94]
9/16/94	6	DECLARATION of Howard A. Grossman Re: . . . his competency to testify in above case. (djc)
9/16/94	7	DECLARATION of George A. Kingsley Re: . . . his competency to testify in above case. (djc)
9/16/94	8	DECLARATION of William A. Barth Re: . . . his competency to testify in above entitled case. . . (djc)
9/16/94	9	MEMORANDUM OF LAW by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth in support of Plaintiffs' Motion for a Preliminary Injunction. (djc)
9/16/94	10	DECLARATION of Timothy E. Quill Re: . . . his competency to testify. . . . (djc)
9/16/94	11	DECLARATION of Samuel C. Klagsbrun Re: . . . his competency to testify. . . . (djc)

9/16/94	12	AFFIDAVIT in support of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: of Motion for a Preliminary Injunction. (djc)
9/16/94	—	ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 . . . to show cause why a preliminary injunction should not be issued. . . IT IS FURTHER ORDERED, that no undertaking be filed by the plaintiffs since it does not appear that any damages may be suffered or. . . . IT IS FURTHER ORDERED, that service of this order to show cause together with a copy of the papers submitted in support hereof upon defendant on or before September 16, 1994 at 1:00 p.m. shall be deemed sufficient service as to defendant; IT IS FURTHER ORDERED, that defendant shall serve, by hand, any affidavits, exhibits and or memorandum of law in opposition upon plaintiffs attorneys on or before September 23, 1994 at 5:00 p.m.; IT IS FURTHER ORDERED, that plaintiffs shall serve any reply affidavits, exhibits and or memoranda upon defendant on or before September 26, 1994. (Signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc)
9/16/94	13	AFFIDAVIT of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: . . . for the purpose of providing the Court with a redacted copy

of the Declaration of Jane Doe, attached as Exhibit A. (djc) [Entry date 09/19/94]

9/16/94 14 NOTICE OF MOTION by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William Barth for Kathryn L. Tucker to appear pro hac vice solely for purposes of this litigation, Return date 9/27/94 (djc) [Entry date 09/19/94] [Edit date 09/19/94]

9/16/94 14 AFFIDAVIT in support of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: [14-1] motion for Kathryn L. Tucker to appear pro hac vice for plaintiffs solely for purposes of this litigation. (djc) [Entry date 09/19/94]

9/16/94 14 AFFIDAVIT in support of Kathryn L. Tucker by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: [14-1] motion for Kathryn L. Tucker to appear pro hac vice for plaintiffs for the purposes of this action. (djc) [Entry date 09/19/94]

9/16/94 — ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 09/19/94]

9/16/94 15 ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 . . . to show why a preliminary injunction should not be issued. . . . (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 09/20/94]

10/6/94 16 ORDER, that the New York State Catholic Conference is granted permission to file a brief as amicus curiae in the above-captioned matter. SO ORDERED. (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc)

10/11/94 17 AFFIDAVIT of Doris J. Barnes Re., served 2 copies of briefs of N.Y. State Catholic Conference on Michael S. Popkin on 10/6/94, Carla A. Kerr on 10/6/94, Kathryn L. Tucker on 10/6/94, by mail. (gb)

10/11/94 18 NOTICE OF CROSS-MOTION by C. Oliver Koppell for judgment on the pleadings. . . . , Return date 10/14/94 (djc)

10/11/94 19 MEMORANDUM OF LAW by C. Oliver Koppell in opposition to Motion for a Preliminary Injunction (djc)

10/11/94 19 MEMORANDUM OF LAW by C. Oliver Koppell in support of [18-1] cross motion for judgment on the pleadings. . . . (djc)

10/14/94 20 REPLY MEMORANDUM by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth in support of Motion for Preliminary Injunction. (djc) [Entry date 10/17/94]

10/14/94 21 DECLARATION in support by Howard A. Grossman for preliminary injunction. (djc) [Entry date 10/17/94]

10/14/94 22 DECLARATION of Minna Barrett in support of plaintiffs' motion to add Governor Mario M.

Cuomo as defendant herein. (djc) [Entry date 10/17/94]

10/14/94 23 DECLARATION of support by Samuel C. Klagsbrun of plaintiffs' motion for a preliminary injunction. . . (djc) [Entry date 10/17/94]

10/14/94 24 SUPPLEMENTAL DECLARATION of support by Timothy E. Quill of Plaintiffs' motion for a preliminary injunction. . . (djc) [Entry date 10/17/94]

10/14/94 25 DECLARATION of Jack Froom, M.D. Re: his competency to testify. . . . (djc) [Entry date 10/17/94]

10/14/94 26 AMENDED COMPLAINT by Timothy E. Quill, Samuel G. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth, (Answer due 10/27/94 for C. Oliver Koppell) amending [1-1] complaint against George A. Kingsley, Mario M. Cuomo; Summons issued. (gb) [Entry date 10/17/94]

10/18/94 27 Order classifying case. Purs. to the Civil Justice Expense and Delay Reduction Plan, this case has been determined to be standard. .NO MEDIATION. (signed by Chief Judge Thomas P. Griesa) (djc) [Entry date 10/19/94]

10/20/94 28 ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 5:00 11/1/94 to show cause by serving, by hand, any supplemental papers in opposition . . why a preliminary injunction should not issue pursuant to Rule 65. . . .

(signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 10/21/94]

10/20/94 29 SECOND AMENDED COMPLAINT by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth (Answer due 11/9/94 for Mario M. Cuomo, for C. Oliver Koppell amending [26-1] amended complaint against Robert M. Morganthau; Summons issued. (djc) [Entry date 10/26/94]

10/28/94 32 ANSWER to Complaint by C. Oliver Koppell, Mario M. Cuomo (Attorney Michael S. Popkin); Firm of: G. Oliver Koppell by attorney Michael S. Popkin for defendant C. Oliver Koppell. (djc) [Entry date 11/01/94]

10/31/94 30 MEMORANDUM OF LAW by Robert M. Morganthau in opposition to Motion for a Preliminary Injunction. (djc) [Entry date 11/01/94]

11/1/94 31 AFFIDAVIT in opposition of Michael S. Popkin Re: to Plaintiffs' Motion for Preliminary Injunction. (djc)

11/1/94 31 AFFIDAVIT in support of Michael S. Popkin Re: [18-1] cross motion for judgment on the pleadings. . . . (djc)

11/3/94 33 RETURN OF SERVICE of Summons and Complaint executed as to Mario M. Cuomo by upon defendant on 10/12/94 Answer due on 11/1/94 for Mario M. Cuomo (djc) [Entry date 11/08/94]

11/3/94 34 RETURN OF SERVICE of Summons and Complaint executed as to Robert M. Morganthau upon defendant on 10/20/94 Answer due on

11/9/94 for Robert M. Morganthau (djc) [Entry date 11/08/94]

11/4/94 36 ORDER, that leave to so amend is granted. Plaintiffs may file and serve such an amended complaint in this matter. (signed by Chief Judge Thomas P. Griesa); Copies mailed (djc) [Entry date 11/16/94]

11/9/94 35 ANSWER by Robert M. Morganthau (Attorney James M. McGuire) to second amended complaint; Firm of: District Attorney by attorney James M. McGuire for defendant Robert M. (djc)

11/28/94 37 SECOND SUPPLEMENTAL DECLARATION in support by Samuel C. Klagsbrun of Plaintiff's motion for a preliminary injunction. (djc) [Entry date 11/29/94]

11/28/94 38 SECOND SUPPLEMENTAL DECLARATION in support by Timothy E. Quill of Plaintiffs' motion for a preliminary injunction. (djc) [Entry date 11/29/94]

11/28/94 39 SECOND SUPPLEMENTAL DECLARATION in support by Howard A. Grossman of Plaintiffs' motion for a preliminary injunction. (djc) [Entry date 11/29/94]

12/2/94 40 AFFIDAVIT of Jerome J. De Cosse, M.D. in support of argument of legal center for defense of life appearing as amicus in support of defts.. (gb)

12/2/94 41 AFFIDAVIT of Richard Gallagher, M.D. in support of Richard Gallagher Re: in support of argument of legal center of defense of life appearing as amicus in support of defts.. (gb)

12/2/94 42 AFFIDAVIT of Joseph George in support of the amicus curiae Legal Center for the defense of life in opposition to pltffs' motion for a preliminary inj. Joseph George M.D. Re: (gb)

12/2/94 43 AFFIDAVIT of Kenneth Prager M.D. Re: in support of the Amicus Curia of the Legal Center for Defense of Life in opposition to pltffs' motion for a preliminary injunction against the enforcement of those portions of sections 125.15(3) and 120.30 of the N.Y. Penal Law which prohibit physician-assisted suicide. . (gb)

12/16/94 44 MEMORANDUM OPINION # 74086 . . . . Plaintiffs' motion for a preliminary injunction is denied.. Defts' motion to dismiss, treated as a motion for summary judgment, is granted, and the action is dismissed. . . SO ORDERED. . (Signed by Chief Judge Thomas P. Griesa); Copies mailed. (kk) [Entry date 12/21/94]

12/21/94 45 JUDGMENT; ORDERED, Adjudged and Decreed: that plaintiffs' motion for a preliminary injunction be and it is hereby denied, and it is further, ORDERED, that defendants' motion to dismiss, treated as a motion for summary judgment, be and it is hereby granted, and it is further ORDERED, that the action be and it is hereby dismissed for the reasons stated in the Court's Opinion, dated December 16, 1994 (signed by Chief Judge Thomas P. Griesa); Mailed copies and notice of right to appeal. EOD - 12/21/94 (djc)

12/27/94	46	Filed Memo Endorsement on letter dated 11/4/94, for leave to file amicus curiae memo of law by the Legal Center for the Defense of Life (signed by Chief Judge Thomas P. Griesa). (cd) [Entry date 01/03/95]
1/3/95	47	NOTICE OF APPEAL by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman; from [45-1] judgment order. Copies of notice of appeal mailed to Attorney(s) of Record: James M. McGuire, Michael S. Popkin. (em) [Entry date 01/05/95]
1/5/95	—	Notice of Appeal and certified copy of docket to USCA: [47-1] appeal by Howard A. Grossman, Samuel C. Klagsbrun, Timothy E. Quill; Copy of notice of appeal sent to District Judge. (em)
2/7/95	48	Transcript of record of proceedings filed for dates of 10/19/94 (rg)
3/2/95	49	Transcript of record of proceedings filed for dates of 10/19/94 (rg)
3/15/95	50	Notice that the record on appeal has been certified and transmitted to the U.S. Court of Appeals: [47-1] appeal by Howard A. Grossman, Samuel C. Klagsbrun, Timothy E. Quill. (rg) [Entry date 03/17/95]
4/26/96	51	STIPULATION and ORDER, extending time to claim attys fees up to and including the 30th day after entry of final judgment in the SDNY. (Signed by Chief Judge Thomas P. Griesa). (lam) [Entry date 04/29/96]

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

95-7028

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants-Appellees,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs-Appellants.

1/6/95	Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman duplicate Form C filed, with proof of service. [95-7028] (cv71)
1/6/95	Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman duplicate Form D filed, with proof of service. [95-7028] (cv71)
1/11/95	Copy of district court docket entries and notice of appeal on behalf of Appellants Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., and Howard A. Grossman, M.D., filed. [95-7028] Form C and D due on 1/13/95. (cv70)

1/11/95 Copy of receipt re: payment of docketing fee filed on behalf of Appellants Timothy E. Quill, M.D., ET AL. receipt. #:229853. [95-7028] (cv70)

1/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman Form C filed, with proof of service. [95-7028] Form C deadline satisfied. (cv71)

1/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman Form D filed, with proof of service. [95-7028] Form D deadline satisfied. (cv71)

1/19/95 Scheduling order #1 filed. Record on appeal due on 2/13/95. Appellant's brief and appendix due on 2/21/95. Appellee's brief due on 3/23/95. Argument as early as week of 4/17/95. (Pre-Argument Conference scheduled for February 2, 1995 at 3:00 P.M.). (cv71)

1/27/95 Letter received from Carla A. Kerr requesting permission for two attorneys to argue appeal. (Ms. Kerr has been notified that a motion is required.) (cv71)

2/2/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to allow permission to divide the time allocated for oral argument between the two lawyers who argued the case below, FILED (w/pfs). [614870-1] (cv71)

2/2/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman AMENDED Form C, filed, with proof of service. (cv71)

2/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to extend time to file brief and to file the motion out time FILED (w/pfs). [616849-1] (cv71)

2/16/95 Order FILED GRANTING motion for extended time [616849-1] by Appellant Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, endorsed on motion form dated 2/13/95. Extended appellant's brief due date is 3/3/95. Extended appellee's brief due date is 4/3/95. Extended argument week as early as 4/24/95. [By: SAB] (cv71)

3/3/95 Notice of appearance form on behalf of Carla A. Kerr, Esq., received. (Orig. to Calendar) (in01)

3/3/95 New party added: Amicus LAMBDA Legal Defense and Education Fund, Inc., National Association of People with AIDS, the Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, the Gray Panthers Project Fund, the Hemlock Society, and Minna Barrett. (cv73)

3/3/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman brief RECEIVED. Problem: no roa index filed. (cv71)

3/3/95 Joint appendix received. Number of volumes: 1. Problem: no roa index filed. (cv71)

3/3/95 Stipulation from Appellants Timothy E. Quill, et al. and Appellee Robert M. Morgenthau, where parties agree that Lambda Legal Defense and Education Fund, Inc., National Association of People with AIDS, the Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, the Gray Panthers Project Fund, the Hemlock Society, and Minna Barrett may file an amici curiae brief, filed. (cv71)

3/3/95 Amicus Curiae Lambda Legal Defense, Nat'l Assoc. People, Unitarian Universali, Americans for Death, Death with Dignity, Gray Panthers Pro-

ject, Hemlock Society, and Minna Barrett brief filed with proof of service. (cv71)

3/15/95 Record on appeal index in lieu of record received. Problem: late. (cv71)

3/16/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to file late record index FILED (w/pfs). [628567-1] (cv71)

3/20/95 Order FILED GRANTING motion to file late [628567-1] by Appellant Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman, endorsed on motion form dated 3/16/95. [By: SAB] (cv71)

3/20/95 Record on appeal index in lieu of record filed. (ag41)

3/20/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman brief FILED with proof of service. (ag41)

3/20/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman joint appendix filed w/pfs. (ag41)

4/3/95 Letters of consent, for the United States Catholic Conference and the New York State Catholic Conference to file an amicus curiae Brief in support of appellees, received. (cv71)

4/3/95 New party added: The United States Catholic Conference and New York State Catholic Conference. (cv71)

4/3/95 Letters received from parties consenting to the filing of an amicus brief by the National Right to Life Committee, Inc. in support of Defendants-Appellees. (cv71)

4/3/95 New party added: The National Right to Life Committee, Inc. (cv71)

4/3/95 Amicus Curiae Nat. Right to Life brief received. Problem: Incorrect caption and docket #. (cv71)

4/4/95 Amicus Curiae Nat. Right to Life brief filed with proof of service. (cv71)

4/4/95 Appellees Dennis C. Vacco, and George E. Pataki brief filed with proof of service. (cv71)

4/5/95 Appellee Robert M. Morgenthau brief filed with proof of service. [SERVICE EFFECTED BY MAIL ON APRIL 3, 1995] (cv71)

4/6/95 Amicus Curiae U.S. Catholic Confer, and NYS Catholic Conference 28(J) letter received with a copy of a Notre Dame. Law Review article which was cited in their amicus brief. (cv71)

4/6/95 Movant Members NYS Legislature brief received. Problem: Motion is missing T-1080. (cv71)

4/7/95 New party added: The New York State Right to Life Committee, Inc. (cv71)

4/7/95 Movant NYS Right to Life brief received. Problem: Motion pending and incorrect color. (cv71)

4/7/95 Movant NYS Right to Life motion to file brief as amicus curiae FILED (W/pfs). [637710-1] (cv71)

4/11/95 Order FILED GRANTING motion to file brief as amicus curiae [637710-1] by Movant NYS Right to Life, endorsed on motion form dated 4/7/95. (cv71)

4/12/95 Amicus Curiae NYS Right to Life brief filed with proof of service. (cv71)

4/12/95 Letter received from Claudia L. Hammerman stating that the amicus brief dated March 3, 1995, inadvertently omitted to include the Euthanasia Research & Guidance Organization (ERGO) as one the interested amici. (cv71)

4/12/95 New party added: Euthanasia Research & Guidance Organization (ERGO), (See letter dated April 10, 1995). (cv71)

4/13/95 New party added: Members of the New York State Legislature. (cv71)

4/13/95 Movant Members NYS Legislature motion to participate as amicus curiae, and to file brief as amicus curiae. FILED (w/pfs). [640243-2] (cv71)

4/17/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman reply brief filed with proof of service. (cv71)

4/18/95 Order FILED GRANTING motion to participate as amicus [640243-1] by Movant Members NYS Legislature, endorsed on motion form dated 4/13/95. GRANTING motion to file brief as amicus curiae [640243-2] by Amicus Curiae Members NYS Legislature, endorsed on motion form dated 4/13/95. [By: GC] (cv71)

4/18/95 Amicus Curiae Members NYS Legislature brief filed with proof of service. (cv71)

5/15/95 Letter received Carla A. Kerr notifying the Court that she is not available for argument May 30 through June 16, 1995. (cv71)

7/10/95 Proposed for argument the week of 8/28/95. (ca93)

7/18/95 Letter received from appellant counsel with an attached affidavit. To Cal. (cv70)

7/21/95 Set for argument on 9/1/95. [95-7028] (ca92)

8/2/95 Letter received from appellant counsel requesting division of time for argument. To Cal. (cv70)

8/7/95 Order FILED GRANTING motion for permission for both counsel to jointly present oral argument on the appeal [614870-1] by Appellant Timothy E.

Quill, Samuel C. Klagsbrun, Howard A. Grossman, endorsed on motion form dated 2/2/95. (ca91)

9/1/95 Case heard before MINER, CALABRESI CJJ., POLLACK D.J. (Tape: #8) (ca95)

4/2/96 Judgment of the district court is AFFIRMED in part & REVERSED in part by published signed opinion filed. (RJM) [95-7028] (cv70)

4/2/96 Judge Calabresi concurring in a separate opinion filed. (cv70)

4/2/96 Judgment filed. (cv70)

4/8/96 Note: The OPINION PRICE is $10.00 (rek)

4/12/96 Appellee Dennis C. Vacco motion for stay Mandate pending application for a Writ of Certiorari, FILED (w/pfs). [784288-1] To A.A. (cv70)

4/12/96 Appellee Dennis C. Vacco papers supporting motion [784288-1] by Appellee Dennis C. Vacco received. Problem: Oversized memo. Contacted counsel & informed him the Court requires a motion to file said memo. (cv70)

4/12/96 Appellee George E. Pataki, Appellee Dennis C. Vacco motion to file oversized memorandum of law FILED (sent to AA) (w/pfs). [786667-1] (cv79)

4/12/96 Letter received from Claudia Hammerman dated 4-11-96 stating that an amicus party had been omitted from the opinion. (cc panel) (cv71)

4/17/96 Order FILED GRANTING motion for stay of mandate pending application for writ of certiorari [784288-1] by Appellee Dennis C. Vacco, endorsed on motion form dated 4/12/96. (RJM, GC, MP) (cv72)

4/17/96	Order FILED MOOTING motion to file oversize memo [786667-1] by Appellee George E. Pataki, Dennis C. Vacco, on motion dated 4/12/96. Moot in light of Court's Order entered this date. (A.H.) (cv70)
4/23/96	Letter sent to atty Carla Kerr from Beth J. Meador returning the stipulation extending time for costs. (cv71)
5/17/96	Letter received from the SC informing this court that a petition for certiorari was filed in this matter. The normal docketing notice will be sent to you in normal course. (cv70)
5/20/96	Notice of filing petition for writ of certiorari for Appellee Robert M. Morgenthau, Appellee George E. Pataki, Appellee Dennis C. Vacco dated 5/16/96 filed. (Supreme Ct#: 95-1858). (cv71)
7/26/96	Letter received from Susan Levy, requesting copy of decision. (cc: K. Brofsky) (cv71)

IN THE SUPREME COURT OF THE UNITED STATES

No. 95-1858

ORDER GRANTING WRIT OF CERTIORARI,
dated October 1, 1996

Tuesday, October 1, 1996

VACCO, NY ATTY. GEN, ET AL. v. QUILL, TIMOTHY, ET AL.

CERTIORARI GRANTED

The motion of Agudath Israel of America for leave to file a brief as *amicus curiae* is granted. The motion of Carl Anderson, Commissioner, et al. for leave to file a brief as *amici curiae* is granted. The motion of United States Catholic Conference, et al. for leave to file a brief as *amici curiae* is granted. The motion of Catholic Medical Association for leave to file a brief as *amicus curiae* is granted. The petition for a writ of certiorari is granted. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, November 12, 1996. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 10,

1996. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, December 27, 1996. Rule 29.2 does not apply. The case is set for oral argument in tandem with No. 96-110, *Washington v. Glucksberg*.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321
Received July 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. Jane Doe is a mentally competent, terminally ill adult who resides in Oceanside, New York.

2. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

3. William A. Barth is a mentally competent, terminally ill adult who resides in New York City.

4. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

5. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

6. Timothy E. Quill, M.D., is a physician licensed in the State of New York who practices internal medicine in Rochester, New York. Dr. Quill sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

7. G. Oliver Koppell, the Attorney General of the State of New York, is the chief law enforcement officer of the State of New York and acts under color of the law in enforcing the New York Penal Law. He is sued in his official capacity and as a representative of all law enforcement officers in the State.

JURISDICTION AND VENUE

8. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343(a)(3).

9. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

10. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

11. Jane Doe is a 76-year-old retired physical education instructor who is dying of thyroid cancer. Jane Doe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of her disease, and that there is no chance of recovery. Jane Doe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Doe seeks necessary medical assistance in the form of medications prescribed by her physician to be self-administered for the purpose of hastening her death. Without such assistance Jane Doe cannot hasten her death in a certain and humane manner.

12. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

13. William A. Barth is a 28-year-old former fashion editor who is suffering from AIDS. Mr. Barth has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease, and that there is no chance for recovery. Mr. Barth is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Barth seeks necessary medical assistance in the form of medications prescribed by his physician and a plaintiff herein, Dr. Howard A. Grossman, to be self-administered for the purpose of hastening his death. Without such assistance Mr. Barth cannot hasten his death in a certain and humane manner.

14. There are mentally competent, terminally ill adults in New York, some of whom would decide to hasten their deaths with physician assistance if such a choice were available to them.

15. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients, including plaintiff William A. Barth, in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

16. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in

a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

17. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Mr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

18. Plaintiffs repeat and reallege paragraphs 1 through 17 of their Complaint.

19. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain

and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

20. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

21. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

22. Plaintiffs repeat and reallege paragraphs 1 through 17 of their Complaint.

23. The Fourteenth Amendment guarantees patient-plaintiffs Jane Doe, George A. Kingsley and William A. Barth, and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

24. Patient-plaintiffs Jane Doe, George A. Kingsley and William A. Barth, and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law are invalid under the Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendant, and all who act in concert with him, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
July 20, 1994

PERKINS COIE
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
1201 Third Avenue, 40th Floor
Seattle, Washington 98101
(206) 583-8888

HUGHES HUBBARD & REED

By: CARLA A. KERR
Carla A. Kerr (CK-5194)

One Battery Park Plaza
New York, New York
(212) 837-6000

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

ANSWER AND AFFIRMATIVE DEFENSES

Defendant G. Oliver Koppell, by and through counsel, answers plaintiff's complaint, as follows:

1. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 1, 2, 3, 4, 5 and 6 of the complaint.

2. In response to paragraph 7 of the complaint, admits that G. Oliver Koppell is the Attorney General of the State of New York and respectfully refers the Court to Section 63 of the New York State Executive Law for a description of his duties and responsibilities.

3. Paragraph 8 of the complaint states legal conclusions to which no responsive pleading is required. The Court is

respectfully referred to the statutes cited therein for their contents.

4. Denies the allegations contained in paragraph 10 of the complaint and respectfully refers the Court to the statutes cited therein for their contents.

5. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14, 15, 16, and 17 of the complaint.

6. In response to paragraph 18 of the complaint, repeats and realleges his answers to paragraphs 1 through 17 of the complaint and incorporates them by reference.

7. Denies the allegations contained in paragraphs 19, 20, and 21 of the complaint.

8. In response to paragraph 22 of the complaint, repeats and realleges his answers to paragraphs 1 through 17 of the complaint and incorporates them by reference.

9. Denies the allegations contained in paragraphs 23 and 24 of the complaint.

FIRST AFFIRMATIVE DEFENSE

10. The complaint fails in whole or in part to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

11. This action is barred in whole or in part by the Eleventh Amendment to the United States Constitution.

12. The Court lacks jurisdiction over the subject matter.

THIRD AFFIRMATIVE DEFENSE

18. This action does not present a case or controversy under Article III of the Constitution of the United States.

FOURTH AFFIRMATIVE DEFENSE

19. The issue presented is a non-justiciable political question.

WHEREFORE, defendant respectfully demands that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
August 22, 1994

G. OLIVER KOPPELL
Attorney General of the
State of New York

/s/ MICHAEL S. POPKIN
SUSAN L. WATSON (SW 0023)
MICHAEL S. POPKIN (MP 3209)
Assistant Attorneys General
120 Broadway—24th Floor
New York, NY 10271
212-416-8570

CERTIFICATE OF SERVICE

MICHAEL S. POPKIN, being duly sworn, deposes and says that he is an Assistant Attorney General employed in the office of G. OLIVER KOPPELL, Attorney General of the State of New York, and that on the 22d day of August 1994 he served the annexed upon Carla A. Kerr, Esq., attorney for plaintiff, of the firm of Hughes, Hubbard and Reed, at her designated professional address at One Battery Park Plaza, New York, NY 10004, by depositing a true and conformed copy of the same with the U.S. Postal Service, first class mail, postage prepaid, for delivery to her in the usual course of its business.

/s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)

Sworn to before me this
22d day of August, 1994

/s/ ILLEGIBLE
Assistant Attorney General
of the State of New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Filed September 16, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

Order to Show Cause

Upon the application of plaintiffs and the accompanying declarations of plaintiffs TIMOTHY E. QUILL, M.D., sworn to on August 26, 1994, SAMUEL C. KLAGSBRUN, M.D., sworn to on August 31, 1994, HOWARD A. GROSSMAN, M.D., sworn to on September 7, 1994, JANE DOE, sworn to on July 28, 1994, GEORGE A. KINGSLEY sworn to on September 13, 1994, WILLIAM A. BARTH, sworn to on September 1, 1994, and the affidavit of CARLA A. KERR, ESQ., sworn to on September 15, 1994, also upon the summons and complaint, and memorandum of law submitted herewith, and upon all prior pleadings and proceedings herein, it is hereby

ORDERED that defendant G. OLIVER KOPPEL show cause before this Court on the 27th day of September, 1994, at 10:00 o'clock a.m., or soon thereafter as counsel may be heard, at the United States Courthouse, Foley Square, New York, New York 10007, in Room 1506, why a preliminary injunction should not be issued pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining defendant, his officers, agents, servants, employees, attorneys, successors in office and all others acting under his authority, control, direction, permission or license, and all persons acting in concert and participation with him from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths;

IT IS FURTHER ORDERED, that no undertaking be filed by the plaintiffs since it does not appear that any damages may be suffered or sustained by any party who is found to be wrongfully enjoined;

IT IS FURTHER ORDERED, that service of this order to show cause together with a copy of the papers submitted in support hereof upon defendant on or before September 16, 1994 at

1:00 o'clock, p.m., shall be deemed sufficient service as to defendant;

IT IS FURTHER ORDERED, that defendant shall serve, by hand, any affidavits, exhibits and/or memorandum of law in opposition upon plaintiffs attorneys on or before September 23, 1994 at 5 o'clock p.m.;

IT IS FURTHER ORDERED, that plaintiffs shall serve any reply affidavits, exhibits and/or memoranda upon defendant on or before September 26, 1994.

Dated: New York, New York
September 15, 1994

/s/ THOMAS P. GRIESA
Chief Judge Thomas P. Griesa
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Received September 15, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

AFFIDAVIT OF CARLA A. KERR, ESQ. IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

CARLA A. KERR, ESQ. declares:

1. I am associated with the law firm of Hughes Hubbard & Reed which, along with Perkins Coie, is counsel for plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., Howard A. Grossman, M.D., Jane Doe, George A. Kingsley, and William A. Barth in the above-captioned action. I am duly admitted to practice before this Court and am fully familiar with the facts and circumstances surrounding this action.

2. I submit this declaration in support of plaintiffs' motion for a preliminary injunction enjoining defendant G. Oliver Koppell from enforcing New York Penal Law sections 125.15(3) and 120.30, which prohibit aiding in a suicide and aiding in a suicide attempt, against physicians who prescribe drugs that suffering, terminally ill patients request to hasten their own impending deaths.

3. Plaintiff Jane Doe was a terminally ill, competent adult who suffered from the effects of the advanced stages of cancer. She died subsequent to the commencement of this action. However, her supporting declaration accompanies this motion. Ms. Doe's signature, in her true name, has been redacted from the Court's copy of the declaration to preserve her privacy. The original signed declaration is maintained in the law offices of Hughes Hubbard & Reed. Due to the advanced stages of AIDS suffered by plaintiffs George A. Kingsley and William A. Barth at this time, we respectfully request that the Court grant the relief sought immediately.

4. Plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D. and Howard A. Grossman, M.D., all licensed physicians who specialize in the treatment of the terminally ill, submit

their declarations and bring this motion on behalf of themselves and their terminally ill patients.

5. The accompanying declarations of the patient plaintiffs evidence the pain and suffering that plaintiffs are forced to endure prior to their deaths because of enforcement of the subject Penal Law provisions. Additionally, the declarations of the physician plaintiffs reflect both their inability to fulfill their professional responsibilities as a result of the Penal Law as well as the suffering of their patients whose interests they assert herein.

6. New York Penal Law section 125.15 provides in pertinent part:

> A person is guilty of manslaughter in the second degree when:
>
> . . .
>
> 3) He intentionally . . . aids another person to commit suicide.
>
> Manslaughter in the second degree is a class C felony.

7. New York Penal Law section 120.30 provides in pertinent part:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.
>
> Promoting a suicide attempt is E felony.

The Penal Law does not criminalize suicide or the attempt to commit suicide, and suicide is not defined by statute.

8. As fully set forth in the accompanying memorandum of law in support of plaintiffs' motion, Penal Law sections 125.15(3) and 120.30 are unconstitutional as applied to physician assistance in dying because the sections intrude upon an individual's fundamental rights to liberty and equal protection which are guaranteed by the Fourteenth Amendment. The

Court in *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992), found that the Constitution affords protection to "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" because they are among the matters "fundamentally affecting a person." Likewise, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 241, 278 (1990), the Court stated that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." The Court in *Cruzan* also acknowledged that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" and in that manner causing his or her own death. *Id.* at 278, 267-68. Thus, the Constitution, supported by the interpretations of the Supreme Court, protects the decision of a mentally competent, terminally ill adult to hasten death with physician assistance. Defendants therefore, must be enjoined from enforcing the subject Penal Law provisions against plaintiffs George Kingsley's and William A. Barth's personal decisions as to whether to hasten their inevitable deaths.

9. The subject sections of the Penal Law also violate the Equal Protection Clause because the sections criminalize the same conduct sanctioned by New York statutory and common law. New York permits individuals, through health care agencies and proxies established while competent, to make all personal health care decisions in the event of incapacity. As fully briefed in plaintiffs' accompanying memorandum of law, relevant case law supports an individual's right to refuse medical treatment, thereby hastening death. This right is considered a "fundamental common-law right" that is "coextensive with the patient's liberty interest protected by the due process clause of our state Constitution." *Rivers v. Katz*, 67 N.Y.2d 485, 493, 504 N.Y.2d 74, 495 N.E.2d 337 (1986). Thus, the Penal Law sections which criminalize physician-assisted hastening of death for the terminally ill prevent one group from receiving the very same protection afforded another group of similarly-situated individuals.

10. The irreparable harm suffered by plaintiffs is clear. The terminally ill plaintiffs have suffered, and in the cases of plaintiffs Kingsley and Barth continue to suffer, both physically and emotionally as outlined in their supporting declarations. Unless this Court issues an injunction, Mr. Kingsley's and Mr. Barth's suffering will increase until they eventually succumb to their disease and the physician plaintiffs will be forced to violate their professional obligations or be subject to criminal prosecution. Likewise absent this issuance of an injunction, the terminally ill patients, on whose behalfs the physician plaintiffs bring this action, will also be prevented from exercising their constitutionally protected right.

11. For the aforementioned reasons, and as discussed in plaintiffs' supporting memorandum of law, plaintiffs have a likelihood of success on the merits.

12. Plaintiffs have no adequate remedy at law.

13. No prior application has been made for the relief requested herein.

/s/ CARLA A. KERR
Carla A. Kerr

Sworn to me before this
15 day of September, 1994

/s/ GEORGE A. TSOUGARAKIS
Notary Public

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in General Internal Medicine and am a Primary Care Internist. I am licensed to practice medicine in the State of New York.

3. I received my medical education at the University of Rochester School of Medicine, graduating in 1976.

4. From 1976 through 1979, I served a residency in Primary Care Internal Medicine with the University of Rochester.

5. I then served a two-year Medical Psychiatric Liaison Fellowship at the University of Rochester School of Medicine.

6. In the 1980–1981 academic year, I served as Senior Instructor in Medicine and Psychiatry at the University of Rochester School of Medicine.

7. From 1981 through 1988, I served as Clinical Assistant Professor of Medicine and Psychiatry at the University of Rochester School of Medicine; in 1982 I received the Clinical Faculty Teaching Award of the Associated Hospitals Program; in 1984 I was the recipient of the Frederick W. Anderson Teaching Award of the Genesee Hospital.

8. From 1981 through 1988, I served as the Medical Director of the Genesee Region Home Care Home Hospice Program.

9. From 1988 through 1989, I served as Assistant Professor of Medicine and Psychiatry at the University of Rochester School of Medicine.

10. From 1990 through 1993, I served as an Associate Professor in Medicine and Psychiatry.

11. In 1994 I was promoted to Professor of Medicine and Psychiatry.

12. From 1989 to the present, I have served as Associate Chief of Medicine at the Genesee Hospital in Rochester, New York. I am also the Director of the Program for Biopsychosocial Studies at the University of Rochester and the Director of a Fellowship in Advanced Biopsychosocial Studies.

13. I am Board Certified by the American Board of Internal Medicine; I am a Fellow of the American College of Physicians; I am a member of Alpha Omega Alpha Society; I am a Diplomat of the National Board of Medical Examiners; I am a member of the Society of General Internal Medicine; I am a member of the Steering Committee, and a senior facilitator for the American Academy on Physician and Patient.

14. I have frequently served as a lecturer, visiting professor, seminar leader, workshop organizer and group facilitator on the subjects of medical interviewing, doctor-patient relationship, psychosomatic medicine and end of life decision making at medical schools, universities, colleges and public forums.

15. I have authored numerous articles, book chapters, and a book on the subjects outlined above, with a recent focus on end-of-life decision making. My full curriculum vitae is attached hereto as Exhibit A.

16. As a Primary Care Internist I treat patients with a wide variety of medical conditions. Some of these conditions include terminal illnesses such as metastatic cancer, AIDS, and end-stage pulmonary disease. As the primary care physician for a patient suffering from any terminal illness, I maintain a trusting relationship with such a patient even though that patient may also be seeing a specialist. I am committed to working with my patients to the end of their lives, no matter what course their illness takes.

17. Patients dying of cancer, AIDS, end-stage pulmonary disease and other terminal illnesses can sometimes experience a steady deterioration of functional ability, intractable pain, fatigue, other unrelievable physical symptoms (nausea, vomiting, shortness of breath, foul-smelling wounds) and mental anguish.

18. At a certain point in the progression of these illnesses there are no further curative treatment options that have a reasonable chance of success. The main goal of treatment under these circumstances is to treat complications, relieve symptoms and maintain personal integrity until death inevitably comes.

19. When effective disease controlling or curing treatments are not available, a variety of care options to maximize the patients' well-being and comfort are available, often under the auspices of a hospice program. I was a hospice medical director for eight years, and believe wholeheartedly in the efficacy and appropriateness of hospice methods and philosophy as the standard of care for dying patients.

20. However, at a certain point in the course of these progressive, terminal diseases, some patients are not able to be kept comfortable while maintaining a clear consciousness; the amount of pain medication necessary to resolve their pain causes loss of mental alertness and sometimes consciousness. Thus, some patients face the choice of enduring intractable pain or surrendering an alert mental state. Many patients will choose one or the other of these options; however some patients do not want to end their ways either wracked with pain or in a drug-induced stupor.

21. Furthermore, other terminally ill patients develop unrelievable physical symptoms such as intractable nausea and vomiting, shortness of breath, foul-smelling wounds and other symptoms. Sometimes these symptoms are also unrelievable short of being sedated to unconsciousness, which some patients find unacceptable.

22. For some terminally ill patients, concerns regarding physical symptoms are secondary to their mental anguish over their helplessness, and loss of independence, physical integrity, dignity and autonomy. Some patients feel as if they are disintegrating as a person, and wish for death as the only way to preserve their integrity.

23. I occasionally encounter mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

24. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

25. Under the statutes prohibiting assisted suicide, my fulfillment of this professional responsibility exposes, and has in the past exposed, me to criminal investigation and/or prosecution. These statutes deter me from treating these patients as I believe I should and deprive my patients of their freedom to choose this type of medical care.

26. I recently had an experience where, in my professional judgment, a terminally ill patient of mine who intentionally chose to hasten her death was making a fully informed, rational decision and my professional responsibility required that I provide medical advice and assistance:

a. In 1990 a patient who had been in my care for 8 years developed acute leukemia. Instead of choosing aggressive medical intervention (chemotherapy, total body irradiation, and bone marrow transplantation) with only a 25 percent chance of cure and multiple, severe adverse side effects, "Diane" chose to spend the time

that she had remaining at home with her family and friends. After ensuring that she was fully informed about what she was giving up, she was offered hospice care to make the most of her remaining life and to ensure that she was kept as comfortable and symptom free as possible. While "Diane" appreciated the benefits of hospice, she feared a lingering death. She wanted to live until her suffering became intolerable, and then she wanted to die as quickly and painlessly as possible. She made it clear that she would act on her own to hasten her death when that point was reached if I refused to assist her in dying and that she would be preoccupied about how to achieve this until she had a fail-safe way out.

b. After extensive discussions with "Diane" and her family, it was my medical judgment that she was making a rational decision to forego treatment and that her desire to hasten her death at the point at which her suffering became intolerable also was rational. I believed "Diane" needed to know that physician-assisted death would be available in order to enjoy her remaining time with her family and friends. I therefore made barbiturates available to "Diane" which she could use to enable sleep, but which she could also take to end her life if all other avenues to relieve her suffering had been exhausted. She agreed to meet with me prior to taking an overdose to ensure that all alternatives had been considered.

c. "Diane" lived for three months after receiving the prescription, in a formal home hospice program. She enjoyed high quality time with her family, and took several life-prolonging treatments such as transfusions and antibiotics. Eventually, "Diane" began to experience such severe pain that she had to make moment-to-moment choices between enduring severe pain or being sedated. She also had fevers indicative of severe infection that were not responding to antibiotics. It was clear that her life expectancy ranged from hours to at most a

week, and that during this time she would experience suffering, anguish and loss of dignity. After meeting with me to ensure that all alternatives had been explored, she took the barbiturates in an overdose and died. She did so alone because she had researched the law in the State of New York, and found that anyone who was with her might be vulnerable to prosecution.

d. In an effort to stimulate discussion about these issues, I subsequently described these events in an article published in the *New England Journal of Medicine*. A copy of this article is attached hereto as Exhibit B. A very public criminal investigation ensued. "Diane's" body, which she had donated to medical science, was subjected to an unwanted autopsy confirming the overdose. A Grand Jury was impaneled to consider whether I should be prosecuted under the New York statute prohibiting assisted suicide. I testified before the Grand Jury, along with "Diane's" spouse and several medical colleagues. The Grand Jury decided against prosecution.

27. I make a commitment to my terminally ill patients that I will not abandon them no matter what happens in the course of their illness. On occasion patients reach a point where their suffering is intolerable and unrelievable and they seek to hasten death. Though relatively few patients actually reach the point where they would act to hasten death, many of my patients fear reaching that point and seek reassurance that I will assist them in dying if they do.

28. I believe that the commitment to help dying patients achieve an end that is acceptable to them is a fundamental professional responsibility for physicians who are committed to the humane care of the dying. I also believe that we have a medical responsibility to respond to those terminally ill patients who reach a point where they are experiencing intolerable suffering that can only be relieved by their deaths. For most patients, hospice care is effective and physician-assisted

death is a reassuring possibility that never has to be acted upon. But for a relatively few dying patients, who suffer intolerably in spite of extensive efforts at palliation, assistance in dying is a welcome alternative to further suffering.

29. Although I was not successfully prosecuted under the New York statutes prohibiting assisted suicide, the fear of having to go through such an ordeal in the future deters me from responding to requests for assistance in dying that I would otherwise deem part of my professional responsibilities.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: August 26, 1994
New York, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

TIMOTHY E. QUILL, M.D.

CURRICULUM VITAE

CURRENT APPOINTMENTS:

Associate Chief of Medicine
The Genesee Hospital, Rochester NY

Professor of Medicine and Psychiatry
University of Rochester School of Medicine and Dentistry

Director, Program for Biopsychosocial Studies

Primary Care Internist

EDUCATIONAL BACKGROUND:

Amherst College, Amherst, Mass.	B.A.	1971
University of Rochester School of Medicine and Dentistry	M.D.	1976
Residency in the Associated Hospitals Program, University of Rochester	R1, R2, R3 Internal Medicine	1976–1979
Fellowship, University of Rochester School of Medicine	Medical Psychiatric Liaison Fellowship	1979-1981

PREVIOUS FACULTY APPOINTMENTS:

Senior Instructor in Medicine and Psychiatry	Univ. of Rochester School of Medicine	1980–81
Clinical Assistant Professor of Medicine and Psychiatry	Univ. of Rochester School of Medicine	1981–88

Assistant Professor of Medicine and Psychiatry	Univ. of Rochester	1988–89
Associate Professor of Medicine and Psychiatry	Univ. of Rochester	1989–94
Professor of Medicine and Psychiatry	Univ. of Rochester	7/94–present

PROFESSIONAL AFFILIATIONS:

American Board of Internal Medicine, Board Certified in 1979
American College of Physicians (Fellow 1986)
Alpha Omega Alpha
National Board of Medical Examiners (Diplomat)
Society of General Internal Medicine
American Academy on Physician and Patient

ACADEMIC AWARDS:

Benjamin Rush Prize for distinguished scholarship and outstanding skills in psychiatry demonstrated while undergraduate medical student, 1976

Graduation speaker to the University of Rochester Medical School Class of 1976

Clinical Faculty Teaching Award, Associated Hospitals Program, 1982

The Frederick W. Anderson Teaching Award, The Genesee Hospital, 1984

LECTURESHIPS AND VISITING PROFESSORSHIPS:

Faculty for SREPCIM Faculty Development Course on the Medical Interview and related skills, Springfield, Mass. —1985

Faculty for National Faculty Development Course on Medical Interviewing, doctor-patient relationships, and communication dynamics. Portland, Oregon, 1987

Faculty at New England SREPCIM Workshop on Medical Interviewing, University of Massachusetts Medical Center—1987

Faculty for regional Faculty Development course on the Medical Interview and Related Skills, Portland, Oregon, 1986

Visiting Professor at the University of North Carolina at Chapel Hill, General Medical Unit, 1987

Visiting Professor at Worcester Memorial Hospital, Worcester, Mass., 1988 Faculty for national Faculty Development Course on Medical Interview and related skills, Brigham and Women's Hospital, Boston, Mass. 1988.

Faculty, Faculty Development Course on Teaching Medical Interviewing and Related Skills, Ben Gurion University Medical School, Israel, 1989.

Workshop Leader, National ACP Meeting, Panic Attacks and Other Anxiety disorders: Recognition and Treatment in Primary Care Practice, San Francisco, CA 4/89

Workshop Leader, National SGIM Meeting, Panic Attacks and Other Anxiety Disorders: Recognition and Treatment in Primary Care, Arlington, VA 4/89.

Faculty, Faculty Development course on the Medical Interview, Univ. of Massachusetts, Worcester, MA 9/89.

Visiting Lecturer on "Anxiety" at Mary McFarland Hospital, Albany Medical College, 12/89

Visiting Professor, Department of Medicine, Oregon Health Sciences University School of Medicine, Portland, Oregon, 2/90.

Workshop leader, "Anxiety Disorders in Primary Care" Symposium, University of Oklahoma College of Medicine, Tulsa, OK, 1/90.

Visiting Professor in the Department of Medicine, Oregon Health Sciences University, Portland, Oregon 2/90.

Faculty, Facilitator Training Course, Tulsa University, Oklahoma City, OK 9/90.

Faculty, Teaching Interviewing Skills Faculty Development Course, University of Oklahoma, Oklahoma City, OK 9/90.

Faculty, SGIM Faculty Development course on Teaching Medical Interviewing, University of Rochester, NY 6/91.

Faculty, AIDS for Primary Care Givers Faculty course, NYU Medical Center, 3/91.

Visiting Professor, Department of Medicine, Yale University, 11/91.

Visiting Lecturer on "Death, Dignity and Individualized Decision Making at Amherst College, Amherst, Mass. 12/91.

Visiting Lecturer on "Negotiating Death: How far should we go?" at Ethics Symposium at the University of Pennsylvania and the VA Medical Center, Philadelphia, PA. 5/92.

Visiting Lecturer on "Comfort Care of the Dying: Potentials and Limitations", Community Hospital of Lancaster, 1/93.

Visiting Professor at Emory University, Department of Psychiatry, Atlanta, Georgia, 2/93.

Visiting Lecturer on "Physician-Assisted Dying: Clinical and Legal Implications" Allegheny Hospital, University of Pittsburgh, 3/93.

Visiting Lecturer on "Physician-Assisted Dying", University of Virginia, Charlottesville, VA, 4/93.

Visiting Professor, New York University Medical Center, NYC, 5/93.

Visiting Lecturer at Medical Ethics Conference, LDS Hospital, University of Utah School of Medicine, Salt Lake City, Utah, 6/93.

Visiting Lecturer on Death and Dignity, Alfred University, Alfred, NY, 9/93.

Visiting Lecturer at Albany Law School, Albany, New York, 11/93

Visiting Lecturer at Cleveland Academy of Medicine, Cleveland, OH, 11/93

Visiting Lecturer at Colorado Springs Osteopathic Foundation, Colorado Springs, Colorado, 11/93.

Visiting Lecturer, North Memorial Med. Center, Robbinsdale, Minnesota, 12/93.

Visiting Lecturer, Rush University, Chicago, Illinois, 12/93.

Visiting Lecturer, Highland Park Hospital, Highland Park, Illinois, 12/93.
Visiting Lecturer, City of Hope Medical Center, Duarte, California, 2/94.
Visiting Lecturer, St. Barnabas Hospital/Cornell Med. Center, Bronx, NY, 2/94.
Visiting Lecturer, Jefferson County Med. Society, Louisville, Kentucky, 3/94.
Visiting Lecturer, St. John Fisher College, Rochester, NY, 4/94.
Visiting Lecturer, St. Luke's/Cook County Hospital, Chicago, Illinois, 5/94.
Visiting Lecturer, Garrett Theological Seminary, Evanston, Illinois, 5/94.

ADMINISTRATIVE ACTIVITIES:

Associate Chief of Medicine, The Genesee Hospital. 3/88–present
Head, Internal Medicine Division, The Genesee Hospital. 1980–present
Director, Fellowship in Advanced Biopsychosocial Studies (1984–present)
Chairman, CPR Committee, The Genesee Hospital
Member, Physician Assistant Committee, The Genesee Hospital

CONSULTANTSHIPS, BOARD MEMBERSHIPS, ADVISORY POSITIONS, SPECIAL ASSIGNMENTS:

Faculty at national and numerous regional and local Faculty Development Courses on the medical interview and related skills sponsored by the Society of General Internal Medicine.
Executive Committee member, American Academy on Physician and Patient, formerly the Task Force on Doctor and Patient of SGIM, 1985 to present.
Medical Director of Hospice Program, Genesee Region Home Care Association. 1984–88

Manuscript Reviewer for *Annals of Internal Medicine*, *Archives of Internal Medicine*, *Journal of the American Medical Association*, and *Journal of General Internal Medicine*.
Development and implementation of a model resuscitation policy at The Genesee Hospital.
Advisory Panel member, American Psychiatric Association's Panic Disorder Committee, 1989.
New York State Primary Care Advisory Panel, 1989
New York State Advisory Panel on Do-Not-Resuscitate, 1990.
Member, Professional Advisory Board, Death with Dignity Education Center, 1994.
Advisor, Task Force on Suicide and Assisted Dying of the American Association of Suicidology, 1994.
Member, Advisory Council, Choice in Dying, Inc. 1993–present

PRESENTATIONS AT MAJOR NATIONAL MEETINGS:

Presentation at SREPCIM Meeting on "Health-Care Seeking by Men During Their Spouse's Pregnancy", Washington DC. 1982
Presentation at SREPCIM Meeting on Medical Interviewing, Springfield, Mass. 1985.
Presentation at SREPCIM Meeting on Somatization, Washington, DC. 1985
Presentation at ABSAME Meeting on Somatization, Chevy Chase, MD. 1985
Presentation at the American Psychosomatic Society Annual Meeting on SREPCIM's approach to teaching about psychosocial aspects of care. Phila., PA. 1987
Presentation at ACP Workshop Improving Clinical Teaching, Cooperstown NY 1987
Presentation at ACP Workshop on Patient Activation, NY, NY. 1988
Presentation on "Diagnosis of Anxiety Disorders", Anxiety Awareness Board Boston, MA 9/88.

Presentation at Anxiety Disorders in Primary Care Symposium on "Assessing the Anxious Patient", Phoenix, AZ 11/88

Presentation on Somatization Disorder to the Canadian Royal College of Physicians, Edmonton, Canada 2/89.

Presentation at National ACP and SGIM Meetings, Panic Attacks & Anxiety Disorders: Recognition & Treatment in Primary Care, Washington, DC 1989.

Presentation at national ACP and SGIM Meetings, Panic Attacks and Other Anxiety Disorders, Chicago and Washington, D.C., respectively, April/May 1990.

Presentation at National SGIM Meeting on Delivering the Bad News. Washington, D.C., 5/90.

Presentation at American Academy of Emergency Physicians' Annual Meeting on Panic Disorder, San Francisco, CA, 9/90.

Presentation at National ACP and SGIM Meetings, Anxiety Disorders and Panic Attacks, New Orleans and Seattle, respectively, April/May 1991.

Presentation on "Panic Disorders" at American College of Emergency Physicians Annual Meeting, Boston, MA 10/91.

Presentation on "Physician-Assisted Dying: Progress or Peril" at the American Society for Law and Medicine Meeting, Chicago, IL. 4/92.

Presentation and workshop coordinator at National ACP Meeting on Biopsychosocial Problems in Primary Care, Washington, DC 5/92.

Presentation at National SGIM Meeting on Aid in Dying and Delivering Bad News. Washington, DC 5/92.

Presentation on "Debate on Active Euthanasia" at National APA Meeting, Washington, DC 5/92.

Presentation on "Assisted Suicide—Moral and Medical Implications" at the Washington National Cathedral, Washington, DC 5/92.

Keynote speaker at Symposium on Patient-Professional Communication and Ethical Issues in the 1900's, Oregon Health Sciences University, Center for Ethics in Health Care, 9/92.

Presentation at Conference on "Care of the Dying Patient", Midwest Bioethics Center, Kansas City, Missouri, 10/92.

Presentation at 1992 Annual Meeting of the American Society of Law and Medicine on "Working with Dying Patients", Boston, MA 2/92.

Presentation at Managing Mortality Conference, Center for Biomedical Ethics, Minneapolis, Minnesota, 12/92.

Presentation at AMA Leadership Conference on "Physician-Assisted Suicide", Atlanta, Georgia, 2/93.

Visiting Lecturer at Massachusetts Medical Society Symposium on Physician Assisted Suicide, Boston, MA, 10/93.

Visiting Lecturer at ACP Regional Meeting, Cape Cod, MA, 10/93.

Visiting Lecturer, American Assoc. of Suicidology, New York, NY, 4/94.

FILMS:

Protagonist for the American College of Physicians' Health Scope Series film entitled "Stress and Illness" 1985-86.

Advisory Board for Television program filming of "Living Well" produced by Vision Associates, NY, NY. (On PBS 1990)

Advisor and Participant in an American Academy of Family Physician and Upjohn Company CME videotape and monograph on "The Diagnosis and Treatment of Anxiety Disorders." (1991)

American Medical Association Documentary on "Medical Ethics", 1992

PUBLICATIONS:

Quill TE, Goldstein M and Schmale A. "Early experience with death in medical school—an approach to sensitization." Paper included in symposium on Thanatology and Medical Education in New York City, 1977.

Schmale A and Quill TE. To Live is to Die—Dealing with Death and Dying. Oncology Module #3, part of the undergraduate psychiatry curriculum (Unpublished)

Quill TE. Care for Chronic Pain (Letter to the Editor). *Annals of Internal Medicine* 94:1(134), January 1981.

Quill TE. Primary Care: How special is medicine's nonspecialty? *The Pharos*, Vol. 45:1, Winter 1982, page 25-30.

Quill TE. Partnerships in patient care: A contractual approach. *Annals of Internal Medicine* 1983;98:228-234.

Lipkin M, Quill TE and Napodano RJ. The Medical Interview: A core curriculum for residencies in internal medicine, *Annals of Internal Medicine* 1984;100:277-284.

Quill TE, Lipkin M, and Lamb GS. Health-care seeking by men in their spouse's pregnancy. *Psychosomatic Medicine* 1984;46:277-283.

Book Review—Quill TE. The Consultation, *Annals of Internal Medicine*, October 1984, Vol. 101:4, p. 577.

Quill TE. (Editorial) Patient-centered medicine: Increasing patient responsibility in medical care. *Hospital Practice*, 1985;20:6-17.

Quill TE. Somatization disorder: One of medicine's blind spots. *JAMA* 1985;254:3075-3079.

Fiore W, Penn TE, Quill T, et.al. Giant cell arteritis in a 20 year old black man: A cause of intermittent calf claudication. *J of Vascular Surgery* 1986;4:192-195.

Quill TE. Where's the Resistance? (Where's the Beef?) *Medical Encounter* (Newsletter of SREPCIM Task Force on the Medical Interview), April 1986, 3:2-4.

Quill TE, Stankaitis JA, Krause CR. The effect of a community hospital resuscitation policy on geriatric patients. *NYS Journal of Medicine*, 1986;622-625.

Quill TE. Medical Resident Education: A Cross-sectional Study of the Influence of the Ambulatory Preceptor as a Role Model, *Archives of Internal Medicine*, 1987;147:971-973.

Quill TE. The Patient with Chronic Pain: A Biopsychosocial Approach. *HMO Practice*, 1987;1:98-104.

Quill TE, Lipkin M, Greenland P. The Medicalization of Normal Variants: The Case of Mitral Valve Prolapse, 1988, *Journal of Gen Int Med* 1988; 3:267-276.

Quill TE. (contributing author) *Diagnosis and Treatment of Anxiety Disorders: A Physician's Handbook*. McGlynn TJ and Metcalf HL (Eds.) American Psychosomatic Press, Inc., 1988.

Quill TE. Recognizing and Calibrating to Barriers in Doctor-Patient Communication. *Ann Intern Med* 1989;111:51-57.

Quill TE. Utilization of Nasogastric Tubes in a Group of Chronically Ill, Elderly Patients in a Community Hospital *Arch of Int Med* 1989; 149:1937-1941.

Quill TE, Williamson PR. Healthy approaches to physician stress. *Arch of Int Med* 1990;150:1857-61.

Rost K, Roter D, Bertakis K, Quill T. Physician-patient familiarity and patient recall of medication changes. *Family Medicine* 1990;22:453-57.

Rost K, Roter D, Quill T, Bertakis K. Capacity to remember drug changes: Deficits associated with diabetes. *Diabetes Res and Clin Prac* 1990:10:183-87.

Quill TE, Townsend P. Bad News: Delivery, Dialogue and Dilemmas. *Archives of Internal Medicine* 1990;151:463-468.

Quill TE. Death and Dignity: A Case of Individualized Decision Making. *NEJM* 1991;324:691-94.

Williams GC, Quill TE, Deci EL, Ryan RM. "The facts concerning the recent carnival of smoking in Connecticut" and Elsewhere. *Ann Int Med* 1991;115:59-63.

Quill TE, Bennett NM. The effect of a hospital policy and state legislation on resuscitation orders for geriatric patients. *Archives of Internal Medicine* 1992;152:569-92.

Quill TE, Cassel C, Meier D. Care of the Hopelessly Ill: Potential Criteria for Physician-Assisted Suicide. *NEJM* 1992;327:1380-84.

Quill TE, Suchman AL. Uncertainty and Control: Illustrations and Possibilities. *Humane Medicine* 1993;9:109-120.

Rabinowitz B, Williams G, Quill TE. Somatization: Why can't we see the forest for the trees. *General Hospital Psychiatry* 1993;15:208-210.

Quill TE. "Doctor I want to die. Will you help me?" *JAMA* 1993;270:870-873.

Quill TE. The Ambiguity of Clinical Intentions. *NEJM* 1993;329:1039-40.

Quill TE, Cassel CK, Meier DE. "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide. Chapter in *Healthcare Ethics: Critical Issues*, Gaithersburg, Aspen Publishers, Inc., 1994.

Quill TE. Cassel CK, Meier DE. "Proposed Clinical Criteria for Physician-Assisted Suicide. Chapter in *Medicine Unbound: The Human Body and the Limits of Medical Intervention*, Volume III in the Emerging Issues in Biomedical Policy series, New York: Columbia University Press, 1994.

Quill TE. Risk taking by Physicians in Legally Gray Areas. *Albany Law Review*, 1994;57:693-708.

Quill TE. From Hubris to Humility: A Resident's Lesson. *Hippocrates*, 1994;8:43.

Quill TE. Exploring Human Suffering: Why the Reluctance? *Bioethics Forum* 1994;10:3-6.

Quill TE, Sussman B, Barold SS. Discontinuing an Implantable Cardioverter-defibrillator as a life-sustaining treatment. *Amer J Cardiology* 1994;74:205-7.

Miller FG, Quill TE, Brody H, Fletcher JC, Gostin LO, Meier DE. Regulating physician-assisted death. *New England Journal of Medicine* 1994;331:119-123.

Quill TE. Physician-Assisted Death: Progress or Peril. *Suicide and Life Threatening Behavior* (In press)

Quill TE. Barriers to Effective Communication. Chapter in *The Medical Interview*, Lipkin, Putnam, Lazare (Ed). New York: Springer-Verlag, 1994 (In Press)

BOOKS:

Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York: W.W. Norton & Co., 1993.

SOUNDING BOARD

DEATH AND DIGNITY
A Case of Individualized Decision Making

Reprinted from the *New England Journal of Medicine*
March 7, 1991

DIANE was feeling tired and had a rash. A common scenario, though there was something subliminally worrisome that prompted me to check her blood count. Her hematocrit was 22, and the white-cell count was 4.3 with some metamyelocytes and unusual white cells. I wanted it to be viral, trying to deny what was staring me in the face. Perhaps in a repeated count it would disappear. I called Diane and told her it might be more serious than I had initially thought—that the test needed to be repeated and that if she felt worse, we might have to move quickly. When she pressed for the possibilities, I reluctantly opened the door to leukemia. Hearing the word seemed to make it exist. "Oh, shit!" she said. "Don't tell me that." Oh, shit! I thought, I wish I didn't have to.

Diane was no ordinary person (although no one I have ever come to know has been really ordinary). She was raised in an alcoholic family and had felt alone for much of her life. She had vaginal cancer as a young woman. Through much of her adult life, she had struggled with depression and her own alcoholism. I had come to know, respect, and admire her over the previous eight years as she confronted these problems and gradually overcame them. She was an incredibly clear, at times brutally honest, thinker and communicator. As she took control of her life, she developed a strong sense or independence and confidence. In the previous $3^{1}/_{2}$ years, her hard work had paid off. She was completely abstinent from alcohol, she had established much deeper connections with her husband, college-age son, and several friends, and her business and her artistic work were blossoming. She felt she was really living fully for the first time.

Not surprisingly the repealed blood count was abnormal, and detailed examination of the peripheral blood smear showed myelocytes. I advised her to come into the hospital, explaining that we needed to do a bone marrow biopsy and make some decisions relatively rapidly. She came to the hospital knowing what we would find. She was terrified, angry, and sad. Although we knew the odds, we both clung to the thread of possibility that it might be something else.

The bone marrow confirmed the worst: acute myelomonocytic leukemia. In the face of this tragedy, we looked for signs of hope. This is an area of medicine in which technological intervention has been successful, with cures 25 percent of the time—long-term cures. As I probed the costs of these cures, I heard about induction chemotherapy (three weeks in the hospital prolonged neutropenia, probable infectious complications, and hair loss; 75 percent or patients respond, 25 percent do not). For the survivors, this is followed by consolidation chemotherapy (with similar side effects; another 25 percent die for a net survival of 50 percent). Those still alive, to have a reasonable chance or long-term survival, then need bone marrow transplantation (hospitalization for two months and whole-body irradiation, with complete killing of the bone marrow, infectious complications, and the possibility for graft-versus-host disease—with a survival of approximately 50 percent, or 25 percent or the original group). Though hematologists may argue over the exact percentages, they don't argue about the outcome of no treatment—certain death in days, weeks, or at most a few months.

Believing that delay was dangerous, our oncologist broke the news to Diane and began making plans to insert a Hickman catheter and begin induction chemotherapy that afternoon. When I saw her shortly thereafter, she was enraged at his presumption that she would want treatment, and devastated by the finality of the diagnosis. All she wanted to do was go home and be with her family. She had no further questions about treatment and in fact had decided that she wanted none. Together we lamented her tragedy and the unfairness of

life. Before she left, I felt the need to be sure that she and her husband understood that there was some risk in delay, that the problem was not going to go away, and that we needed to keep considering the options over the next several days. We agreed to meet in two days.

She returned in two days with her husband and son. They had talked extensively about the problem and the options. She remained very clear about her wish not to undergo chemotherapy and to live whatever time she had left outside the hospital. As we explored her thinking further, it became clear that she was convinced she would die during the period of treatment and would suffer unspeakably in the process (from hospitalization, from lack or control over her body, from the side effects of chemotherapy, and from pain and anguish). Although I could offer support and my best effort to minimize her suffering if she chose treatment, there was no way I could say any or this would not occur. In fact, the last four patients with acute leukemia at our hospital had died very painful deaths in the hospital during various stages of treatment (a fact I did not share with her). Her family wished she would choose treatment but sadly accepted her decision. She articulated very clearly that it was she who would be experiencing all the side effects or treatment and that odds or 25 percent were not good enough for her to undergo so toxic a course of therapy, given her expectations of chemotherapy and hospitalization and the absence of a closely matched bone marrow donor. I had her repeat her understanding of the treatment, the odds, and what to expect if there were no treatment. I clarified a few misunderstandings but she had a remarkable grasp of the options and implications.

I have been a longtime advocate of active informed patient choice of treatment or nontreatment, and of a patient's right to die with as much control and dignity as possible. Yet there was something about her giving up a 25 percent chance or long-term survival in favor of almost certain death that disturbed me. I had seen Diane fight and use her considerable inner resources to overcome alcoholism and depression, and

I half expected her to change her mind over the next week. Since the window of time in which effective treatment can be initiated is rather narrow, we met seven times that week. We obtained a second hematology consultation and talked at length about the meaning and implications of treatment and nontreatment. She talked to a psychologist she had seen in the past. I gradually understood the decision from her perspective and became convinced that it was the right decision for her. We arranged for home hospice care (although at that time Diane felt reasonably well, was active, and looked healthy), left the door open for her to change her mind, and tried to anticipate how to keep her comfortable in the time she had left.

Just as I was adjusting to her decision, she opened up another area that would stretch me profoundly. It was extraordinarily important to Diane to maintain in control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die. As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense. I acknowledged and explored this wish but also thought that it was out of the realm of currently accepted medical practice and that it was more than I could offer or promise. In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left until she found a safe way to ensure her death. I feared the effects of a violent death on her family, the consequences of an ineffective suicide that would leave her lingering in precisely the state she dreaded so much, and the possibility that a family member would be forced to

assist her, with all the legal and personal repercussions that would follow. She discussed this at length with her family. They believed that they should respect her choice. With this in mind, I told Diane that information was available from the Hemlock Society that might be helpful to her.

A week later she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

The next several months were very intense and important for Diane. Her son stayed home from college, and they were able to be with one another and say much that had not been said earlier. Her husband did his work at home so that he and Diane could spend more time together. She spent time with her closest friends. I had her come into the hospital for a conference with our residents, at which she illustrated in a most

profound and personal way the importance of informed decision making, the right to refuse treatment, and the extraordinary personal effects of illness and interaction with the medical system. There were emotional and physical hardships as well. She had periods or intense sadness and anger. Several times she became very weak, but she received transfusions as an outpatient and responded with marked improvement of symptoms. She had two serious infections that responded surprisingly well to empirical courses of oral antibiotics. After three tumultuous months, there were two weeks of relative calm and well-being, and fantasies of a miracle began to surface.

Unfortunately, we had no miracle. Bone pain, weakness, fatigue, and fevers began to dominate her life. Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to her husband and son that morning and asked them to leave her alone for an hour. After an hour which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace. They asked me for advice about how to proceed. When I arrived at their house, Diane indeed seemed peaceful. Her husband and son were quiet. We talked about what a remarkable person she had been. They seemed to have no doubts

about the course she had chosen or about their cooperation, although the unfairness of her illness and the finality or her death were overwhelming to us all.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF SAMUEL C. KLAGSBRUN, M.D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing psychiatry and I am licensed to practice medicine in the State of New York.

3. I received my medical education at the Chicago Medical School, graduating in 1962.

4. I then completed an internship at the Michael Reese Hospital in Chicago in 1963, where I received the Intern of The Year award.

5. From 1963 through 1966, I served a psychiatric residency at the Yale New Haven Hospital in New Haven, Connecticut.

6. From 1966 through 1968, I was Chief of Psychiatry at the New London Submarine Base in New London, Connecticut. During this time I also served as a Staff Psychiatrist at the New London Child Guidance Clinic and was a Clinical Instructor in Psychiatry at Yale Medical School.

7. In 1968 I began a private practice in New York City. Between 1968 and 1974 I also served in various capacities at St. Luke's Hospital in New York, New York including as Director of the Psychiatric Day Hospital (1969-71) and Director of Psychiatric Consultation Service (1971-74).

8. From 1971 thorough 1988, I served as Associate Clinical Professor in Psychiatry at the Columbia University College of Physicians and Surgeons in New York City. From 1988 to the present, I have served as a Lecturer at Columbia.

9. From 1977 to the present, I have served as Executive Medical Director at the Four Winds Hospitals located in Katonah, New York and Saratoga Springs, New York.

10. From 1975 to the present, I have been a Senior Advisor at St. Christopher's Hospice, London, England.

11. I am a member of the American Medical Association, the American Psychiatric Association, the American Group Psychotherapy Association, and the American Association of Suicidology. I am a Committee Member of the American Cancer Society Public Education Section, a Member of the Board of Directors of the New York City division of the American Cancer Society, and an Executive Committee Member of the Westchester County Mental Health Association. I have served as Chairman of the Westchester County Mental Health Association Education Committee.

12. I have published numerous articles, papers and chapters in medical journals and textbooks. Many of these address care of dying patient. My complete curriculum vitae is attached hereto as Exhibit A.

13. Throughout my career I have provided psychiatric treatment to patients dying of terminal illnesses, particularly patients dying of cancer.

14. Most cancer patients experience progressive loss of appetite, weight, and increasing pain and fatigue. As a result, they also lose their ability to care for their own needs. In addition, there are a myriad of other problems related to the specific sites of the cancer. Those with cancer of the lung, for example, experience terrible shortness of breath and coughing. Those with brain cancer often experience excruciating headaches, seizures and progressive loss of brain function.

15. Cancer usually progresses steadily and slowly over a period of months. The cancer patient is fully aware of his or her present suffering and anticipates future suffering. The terminal cancer patient faces a terrifying future. Near the end, the cancer patient is usually bedridden and experiences a rapid loss of physical and mental functions. The patient also often experiences excruciating, unrelenting pain.

16. Pain management at the end stage of cancer often requires the patient to choose between enduring unrelenting pain or sacrificing an alert mental state to the high dose of drugs adequate to alleviate the pain. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

17. I occasionally encounter mentally competent patients who are dying of cancer, who understand their condition, diagnosis, and prognosis, and who wish to avoid prolonged suffering by hastening their deaths. For some of these patients the paramount concern is the loss of control over their destiny, the intolerable dependency on their caretakers, and the awful sense of helplessness in their daily routines. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

18. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational, and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

19. Under the statutes prohibiting assisted suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statutes deter me from treating these patients as I believe I should.

20. The statutes prevent patients from making fundamental decisions about medical care, their lives, their suffering and their dignity. I recently had an experience, described below in detail, where, in my professional judgment a terminally ill patient of mine who desired to hasten his inevitable death was making a fully informed, rational decision and my professional judgment was that I should assist this patient in effectuating this choice; however, the statutes deterred me from doing so.

a. I once treated a patient to whom I shall refer as Ms. Jones. She was a 39-year old married woman, the mother of two children, and an accountant by profession. After being diagnosed with breast cancer, Ms. Jones underwent a mastectomy and then received radiation and chemotherapy. Ms. Jones subsequently was able to return to work on a part-time basis.

b. Ms. Jones came to me for psychotherapy, as did her husband. Her goal was to ensure that her approach to managing her illness was as sensible as possible, given the need to minimize the trauma to her children. Ms. Jones has always lived her life in a sensible and practical fashion. She had taken charge of her life by seeking sensible approaches to her problems.

c. More than a year later after she came to be in my care, notwithstanding the excellent medical care she had received for her cancer, Ms. Jones began experiencing severe and unrelenting headaches. A brain scan indicated that the cancer had metastasized to her brain. Ms. Jones underwent brain surgery to remove the tumor. She understood that her prognosis at this point was extremely poor, that there were no curative treatments, and that she was in the terminal phase of her illness. Ms. Jones began to explore alternatives, including the possibility of hastening her death should her suffering become intolerable.

d. Ms. Jones asked me if I would help her die in a painless and humane fashion by prescribing drugs she could take to hasten her death when her suffering became intolerable. I determined after extensive discussions with Ms. Jones, based on my extensive clinical experience in providing psychiatric care to terminally ill patients, that Ms. Jones's request was not caused by depression or any other mental disability. I knew that Ms. Jones was a brave, courageous woman, who was attempting to take charge of events and make an important decision by rationally considering her circum-

stances. My medical opinion was that she was asking me to help her attain a reasonable goal. However, given the current legal prohibition, I was compelled to deny her request.

e. Some months later, Ms. Jones began experiencing double vision, and it was determined that the brain cancer had spread. Still fully mentally competent, and suffering terribly, she implored me to assist her in hastening her death. I refused, and felt that I was performing a medical disservice in doing so.

f. Ms. Jones's husband called me a few days later and informed me that Ms. Jones was suffering constant nausea and intractable pain, and that she found life in this condition intolerable. Her family was devastated by having to watch her extreme suffering. Ms. Jones died several days later after further suffering.

g. At Mr. Jones's request, I treated the Jones children briefly after their mother's death. They were having emotional difficulties, not with her death, which their mother had prepared them for extremely well, but with the image of her terrible, lingering suffering at the end of her life. The image of her suffering was much more destructive to her children than her death, which they viewed as a peaceful solution to an intolerable situation.

h. I believe I failed in my duty to Ms. Jones by refusing her what I felt was an acceptable medical option for her to choose in these circumstances, *i.e.*, assistance in hastening her inevitable death in a certain and humane fashion.

i. The case of Ms. Jones is one of a number of similar cases I have experienced in my medical practice. I have witnessed these patients die in an inhumane and undignified manner after prolonged periods of extreme physical and psychological suffering. They desired to avoid

this suffering by hastening death in a humane manner, but were unable to do so.

21. The statutes prohibiting assisted suicide deter me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: August 31, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

Exhibit A

SAMUEL CHARLES KLAGSBRUN, M.D.

FOUR WINDS HOSPITAL
800 Cross River Road
Katonah, N.Y. 10536
(914) 763-8151

PERSONAL DATA

Date of Birth:	September 23, 1932
Place of Birth:	Belgium
Marital Status:	Married, one child
Citizenship:	U.S. (1946)

DEGREES, LICENSURES, CERTIFICATIONS:

1979	Fellow–American Psychiatric Association
1977	Diplomate–American Board of Psychiatry and Neurology New York State License #090545
1963-66	Psychiatric Residency–Yale New Haven Hospital
1963	Rotating Internship–Michael Reese Hospital, Chicago
1962	M.D.–Chicago Medical School
1955	B.A.–CCNY
1954	BRE–Jewish Theological Seminary

AWARDS

1963	Intern of the Year Award–Michael Reese Hospital
1954	PSI CHI (Psychology Honor Society)–CCNY
1954	Gittleson Award for Scholarship–JTS

PROFESSIONAL EXPERIENCES

1968-80	Private Practice, New York City
1966-68	Chief of Psychiatry, New London Submarine Base, Conn.
1966-68	Staff Psychiatrist, New London Child Guidance Clinic

TEACHING AND HOSPITAL POSITIONS

1977-Present	Executive Medical Director–Four Winds Hospitals, Katonah, N.Y.; Saratoga Springs, N.Y.
1975-Present	Visitor–St. Christopher's Hospice, London, England
1971-1988	Associate Clinical Professor in Psychiatry–Columbia University College of Physicians and Surgeons
1988-Present	Lecturer–Columbia University College of Physicians and Surgeons
1973-Present	Visiting Professor and Chairman–Pastoral Psychiatry, Jewish Theological Seminary
1971-74	Director–St. Luke's Hospital–Psychiatric Consultation Service
1968	Supervisor of Group Psychotherapy, St. Luke's Hospital
1969-71	Director–Psychiatric Day Hospital, St. Luke's Hospital
1968-1969	Associate Director–Psychiatric Walk-In Clinic, St. Luke's Hospital
1966-1968	Clinical Instructor in Psychiatry–Yale University School of Medicine Lecturer–Annual course on "Management of the Dying Patient" given at various New York hospitals Visiting lecturer–NYU School of Social Work

MEMBERSHIP IN ASSOCIATIONS

American Medical Association
American Psychiatric Association
American Group Psychotherapy Association
Committee Member of American Cancer Society Public Education Section
Board of Directors, NYC Division of American Cancer Society
Member of Executive Committee Thanatology Foundation
Associate Editor, Journal of Thanatology
Past Committee Member, Continuing Education, NY District Branch of APA
Chairman, Long-Term Committee, Westchester Division of APA
Member of American Association of Suicidology
Board of Directors, National Committee on Youth Suicide Prevention, NY
Executive Committee Member, Westchester County Mental Health Assoc.
Chairman, Westchester County Mental Health Association Education
Committee Board of Trustees, Westchester/Hudson Valley Chapter, Leukemia Society of America

PUBLICATIONS AND PAPERS

Klagsbrun, S.C.; *Patient, Family, and Staff Suffering*. Journal of Palliative Care 10:2/1994; 14-17.

Klagsbrun, S.C.; *Physician-Assisted Suicide: A Double Dilemma*. Journal of Pain and Symptom Management, Vol. 6, No. 5, July 1991.

Klagsbrun, S.C.; Kutscher, A.H; Bess, S; Siegel M.E.; Cherico, D.J.; Kutscher, L. G.; Peretz, D.: Selder, F. E. (Editors) *For the Bereaved: The Road to Recovery*. Philadelphia: The Charles Press, 1989.

Klagsbrun, S.C.; Kliman, Gilbert W.; Clark, Elizabeth J.; Kutscher, Austin, H.; DeBellis, Robert; Lambert, Carole A. (Editors) *Preventive Psychiatry: Early Intervention and Situational Crisis Management.* Philadelphia: The Charles Press, 1989.

Klagsbrun, S.C. *Psychosocial Aspects of Isolation in the AIDS Patient* The New york Medical Quarterly, 1988 P 10-14.

Klagsbrun, S.C.; Goldberg. I.K; Rawnsley, M.D.; Kutscher, A.H.; Marcus, E.R.; Siegel, M.E. (Editors): *Psychiatric Aspects of Terminal Illness* Philadelphia: The Charles Press, 1988.

Klagsbrun, S.C.; Reibel, J.S.; Piercey, M.C. *Cost Effective Tertiary Care* Psychiatric Clinics of North America, 1987.

Network of Trust Can Help Prevent Teenage Suicide, Atlanta Journal, March 22, 1987.

DeBellis, R; Kutscher, A.H.; Goldberg, M.R; Cherico, D.J.; Klagsbrun S.C.; and Pritchard, E.R. (Editors): *Continuing Care: For the Dying Patient, Family and Staff.* New York: Praeger Publishers, 1985 176 pp.

Margolis, O.S.; Raether, H.C.; Kutscher, A.H.; Klagsbrun, S.C.; Marcus, E.R.; Pine, V.R.; and Cherico, D.J. (Editors): *Loss, Grief, and Bereavement: A Guide for Counseling.* New York: Praeger Publishers, 1985, 155 pp.

Klagsbrun, S.C. *The Making of a Cancer Psychotherapist.* Journal of Psychosocial Oncology, 1983, Winter Vol. 1(14) P 55-60.

Kutscher, A.H.; Klagsbrun, S.C.; Torpie, R.J.; DeBellis, R.; Hale, M.S. and Tallmer, M. (Editors): *Hospice U.S.A.* New York: Columbia University Press, 1983, 304 pp.

The Politics of Expanding Hospice Care, Part 1, No. 4, and A Psychiatric Setting and Total Care, Part VI, No. 26, in Kutscher, A. and Kutscher, L. (Editors): Hospice U.S.A., New York: Columbia University Press, 1983.

Klagsbrun, S.C. *Ethics in Hospice Care* American Psychologist, Vol. 37, No.11, P 1263-1265, November 1982.

Klagsbrun, S.C. *The Management of the Dying Patient and Death* pp. 447-460, from Psychiatric Management for Medical Practitioners Edited by Donald Kornfeld and Jerry Finkel. New York: Grune & Stratton, 1982.

Kutscher, A.H.; Peretz, D.; Klagsbrun, S.C.; Cherico, D.J. and Kutscher, L.G. (Editors): *For Those Bereaved—But Not to Lose: A Book of Comfort* (revised edition). New York: Arno Press/New York Times Company, 1980, 331 pp.

Totality of Care from Birth to Death, in Pritchard, E., et al (Editors): Home Care—Living With Dying. New York, Columbia University Press, 1979.

Chapter in Kutscher, et al (Editors): *Dialogues—The Living and the Dying.* New York: Arrow Press, 1978.

Klagsbrun, S.C. *Breast Cancer, Confronting One's Changed Image. Don't Make Nice, Make Real.* American Journal of Nursing, September 1977, 77(9), P 1432.

Chaplains Who Can't Hear Published lecture Annual Meeting of Episcopal Hospital Chaplains, March 12 1973, Atlanta, GA Institute of Religion and Medicine, Chicago, IL

Kaufman, E., Klagsbrun, S.C. *An Emergency Room Changes: (Impact of Psychiatric Walk-In Clinic on Emergency Room of General Hospital)* Diseases of the Nervous System, April 1972, 33(4), P 231-234.

Klagsbrun, S.C. *Communications in the Treatment of Cancer* Kango-Gijutsu, September 1971, 17(9), P 90-98

Klagsbrun, S.C. *Communications in the Treatment of Cancer* American Journal of Nursing, May 1971, 71(5), P 944-948.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* Del-Med-Journal, May 1970, P 117-120.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* RN, January 1970, 33(1) P 46-51.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* American Journal of Psychiatry, March 1970, 126(9), P 1237-44.

Klagsbrun, S.C. *An Analysis of Groups That Never Were* International Journal of Group Psychotherapy, April 1969, 19(2), P 142-149.

Klagsbrun, Francine and Klagsbrun, Samuel *Your Health: Nutrition* New York, Watts, 1969.

Rehabilitation in Cancer: The Psychiatric Viewpoint Published proceedings of the Symposium on Rehabilitation and Cancer. American Cancer Society, November 20, 1969.

Klagsbrun, S.C. *In Search of an Identity* Arch-Gen-Psychiatry, March 1967, 16(3), P 286-289.

Klagsbrun, S.C. *The Effects of Bias on Clinical Judgement* Chicago Medical School Quarterly, Spring 1962, 22: P 114-118.

LECTURES

Visiting Nurses Service, "Truth Telling in Hospice," June 10, 1993

Home Care Association of New York State, "Ethics in Home Care," May 10, 1993

White Plains Hospital, "Terminal Illness and Assisted Death," May 5, 1993

Middletown Psychiatric Center, "Domestic Violence—Psychiatric Aspects," April 14, 1993

Albert Einstein College of Medicine, Grand Rounds, "Cancer and Emotions," April 30, 1993

YM and YWHA of Mid-Westchester, "Understanding the Jewish Battered Woman's Dilemma," March 18, 1993

American Academy of Psychiatry and the Law, "Physician Assisted Suicide," January 23, 1993

The New York Conference of the Elie Wiesel Foundation for Humanity, Presentation and Chair: Health, Family, & Poverty, November 16, 1993

University of Connecticut, "Socio-Psychological Conflicts in Modern Jewish Life," November 15, 1992

Four Winds Hospital/Saratoga, "Psychiatric Issues In Treatment of Cancer Patients," October 2, 1992

Metropolitan Hospital, "Recovery and Resentment in Addiction," September 25, 1992

New York Medical College, "Recovery and Resentment in Addiction," September 24, 1992

New York Ethical Culture Society, "Loss, A Time For Growth," March 13, 1992.

Cancer Care, "Suicide and the Cancer Patient," December 12, 1991

National Association of Psychiatric Treatment Centers for Children, "The Need for Inpatient Care," November 21, 1991

Putnam Hospital, "Parenting Adolescents in the 90's," November 19, 1991

American Cancer Society, "Cancer Survivors in 1990's," November 13, 1991

Westchester Coalition of Family Violence Agencies, "What You Don't Know About Domestic Violence Could Kill Your Client, Therapeutic Techniques and Legal Remedies," October 30, 1991

Central Labor Rehab Council of New York, "Denial," October 22, 1991

Alliance for the Mentally Ill in Ulster County (AMI), "Must Life be Measured by the Dollar: Fighting for the Severely Ill," October 9, 1991

Columbia Presbyterian, "Terminally Ill Patients," September 25, 1991

Behavioral Healthcare Conference, Boston, "Long-Term Psychiatric Hospitalization," September 5, 1991

Westchester County Medical Center, Randy Polk Endowment Lecture, "Relationship Between Health Care Professionals and Seriously Ill Patients in the 90's: Is It At Risk?," June 6, 1991

Westchester County Medical Center, Randy Polk Endowment Lecture, "Assisted Suicide: A Problem for Modern Medicine," May 24, 1991

APA, Workshop: The Psychiatrist and the Dying Patient; Paper. "When Religious Behavior is a Symptom," May 14-16, 1991

BOCES, West County, "Balancing Stress and Excellence: The Adolescent's Challenge," May 9, 1991

MHA Benefit, Keynote Address, May 8, 1991

New York Center for Recovery, Lecture to counselors receiving substance abuse training, May 2, 1991

Columbia Presbyterian, "Dying Patient," May 1, 1991

Hofstra University Conference, "The Legal Profession in the 1990's: Is a Life in the Law Getting Better or Worse?," Panel on "The Psychological Tensions of Professional Life," April 19, 1991

Bergen Pines County Hospital, "The Sandwich Generation: Caught Between Children and Aging Parents," March 28, 1991

Jewish Theological Seminary, "Substance Abuse, Suicide, Mental Health and the Role of the Rabbi and Hazzan," February 21, 1991

Albany Medical Center, "Physician Assisted Suicide: Moral or Immoral?," January 23, 1991

Pace University Law School, "Does Religion Interfere with Mental Health?," January 9, 1991

RESEARCH INTERESTS:

Psychosomatic medicine with emphasis on the correlation between emotions and cancer. Adolescent Suicide

Battered Women Syndrome

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF HOWARD A. GROSSMAN, M.D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in Internal Medicine. Approximately 50 percent of my patients are infected with the Human Immunodeficiency Virus ("HIV").

3. I received my medical education at the State University of New York at Downstate School of Medicine in Brooklyn, New York, graduating in 1983.

4. From 1983 through 1986, I served a residency in Internal Medicine at the Kings County Hospital Center in Brooklyn, New York.

5. In 1987 I served as an Attending Physician in the Spellman Center for the Treatment of HIV-related Diseases at St. Clare's Hospital in New York City.

6. From 1987 through 1988, I served as Attending Physician in the Department of Medicine at the Bellevue Medical Center's Community Health Project, a satellite clinic designed to identify and treat those at high risk for HIV-related diseases.

7. From 1987 through 1990, I also served as Attending Physician at St. Clare's Hospital in New York City.

8. At present I am in private practice and serve as Attending Physician at St. Luke's/Roosevelt Hospital and St. Vincent's Hospital in New York City.

9. I have been involved with numerous research projects relating to treatment of persons infected with HIV and have lectured extensively regarding treatment of people with Acquired Immune Deficiency Syndrome ("AIDS").

10. I serve on the Board of Directors of the Gay Men's Health Crisis. I am a member of the AIDS Task Force of the

New York County Medical Society; the Physicians Advisory Committee to the Community Research Initiative on AIDS; the American College of Physicians; and the New York State/County Medical Society. I am a Board Member of the American Association of Physicians for Human Rights and past President of New York Physicians for Human Rights. I served on the former Scientific Advisory Board for Treatment Directory of the American Foundation for AIDS Research.

11. I am certified by the American Board of Internal Medicine and am a Diplomate of the National Board of Medical Examiners. My complete curriculum vitae is attached hereto as Exhibit A.

12. HIV infection produces a progressive destruction of the immune system, leading to AIDS, which is inevitably fatal. Persons with AIDS are vulnerable to a variety of unusual infections, cancers, and other syndromes such as wasting (chronic diarrhea/weight loss), peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs), and dementia (loss of cognitive function). Death is often preceded by a prolonged period of illness and debility. As medical science becomes able to prevent and treat certain AIDS-related infections, patients develop more debilitating cancers and infections for which no treatment is available.

13. Patients with AIDS may die in many different ways. Many suffer from forms of cancer commonly seen with AIDS such as aggressive, disseminated lymphoma or Kaposi's Sarcoma. These patients may die from invasion of cancer into the lungs, causing progressive difficulty breathing and ultimately death by suffocation. Many die of pneumonia, which also causes the patient to essentially suffocate. Many with wasting disease basically die of starvation and dehydration, an excruciating process that may continue for weeks. Some patients lose so much weight that they appear skeletal and suffer such ravages of malnutrition as the inability to walk, skin deterioration and hydration. Still others die as the result of any one of several types of massive infections that resist treatment.

14. Many AIDS patients who will die of the above-described causes also suffer from conditions which themselves cause extreme pain and suffering. Examples include CMV retinitis, which leads to loss of vision and eventually blindness; neuropathy, which sometimes causes pain so agonizing that it can be relieved only by a dosage of narcotics which impairs consciousness; Kaposi's Sarcoma of the skin, which can produce severe disfigurement and pain from swollen tissues and open, weeping skin lesions.

15. Medicines can palliate the dying process in many cases. The majority of the time, I am able to ameliorate the symptoms of a dying patient so that the patient can be relatively free from pain and discomfort while dying. However, in some cases, the pain, discomfort, and loss of dignity can be relieved only with drugs which render the patient unconscious; in some cases even such aggressive use of drugs does not bring relief. In my practice I have had numerous AIDS patients receiving hospice care who repeatedly express frustration at how long the process is taking, and how painful, uncomfortable, and humiliating it is. Some of these patients have made repeated requests that their dying process be hastened.

16. I occasionally encounter mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

18. Under the statutes prohibiting assisted suicide, fulfillment of this professional responsibility would expose me to criminal prosecution. The statutes deter me from treating these patients as I believe I should.

19. The statutes have resulted in patients of mine dying tortured deaths.

20. One patient of mine, whom I will call Smith, was a vibrant active designer and AIDS activist who did not want to endure wasting and dementia before he died. While fully mentally competent and unquestionably in the end stage of AIDS, he requested my assistance in hastening his death, which I could not provide. This patient soon began experiencing a process of severe wasting, skin deterioration, chronic vomiting and, ultimately, dementia. He became disoriented and confused and unable to care for himself. The process continued for approximately six weeks before Smith died.

21. Such a prolonged dying period is inhumane to the patient, who must suffer against his wishes, and to the loved ones, who frequently express the belief that "we are kinder to our pets than we are to the terminally ill." After death, the survivors express guilt about the suffering their loved one endured, and the doctor feels remorse that the patient's suffering could not have been curtailed.

22. I have known AIDS patients who committed suicide relatively early in the course of the disease, apparently because of the fear that a death like that of patient Smith would be their fate. These individuals prematurely end their lives because they feel unable to discuss their fears with me and anticipate a death preceded by unrelieved suffering. As a physician, I have wished that I could have prevented their premature deaths by committing to help them through the subsequent stages of their illness, including, if they choose at the time, to hasten their deaths.

23. I also have known AIDS patients who attempt to commit suicide and fail. Often the failed attempt results in increased anguish and physical disability.

24. One of my current patients is plaintiff William A. Barth, who is known by his nickname "Willy." I have treated Willy regularly since 1989 and know him well. Currently we are pursuing an aggressive course of therapy to control his disease. In my medical judgment, Willy is mentally competent and should be able to request and receive my assistance in dying when his suffering becomes intolerable to him. Based on my extensive clinical experience in treating patients dying of AIDS, I have no question that Willy's condition is terminal, and that he will suffer severe pain and physical deterioration in the future. This will occur despite the availability of hospice care and aggressive pain management. Willy's decision whether or not to exercise a choice to hasten his death would be based on a full understanding of his condition, prognosis and medical care options.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 1, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

HOWARD A. GROSSMAN, M.D.
Internal Medicine
285 West 11th Street, Suite 1-W
New York, New York 10014
Telephone (212) 929-2629

Prepared November 1, 1993

PERSONAL DATA

Birthdate April 20, 1954
Birthplace Newark, New Jersey

EDUCATION AND POST-GRADUATE TRAINING

1983–1986 KINGS COUNTY HOSPITAL CENTER
Resident, Internal Medicine
Department of Medicine,
451 Clarkson Avenue, Brooklyn, NY 11203

1979–1983 SUNY-DOWNSTATE SCHOOL OF MEDICINE,
Brooklyn, NY
M.D., received May, 1983

1976–1978 COLUMBIA UNIVERSITY, NY, NY
School of General Studies,
post-baccalaureate pre-medical program

1972–1976 HAVERFORD COLLEGE, Haverford, PA
B.A., political science, received May, 1976

CERTIFICATION AND LICENSURE

American Board of Internal Medicine Certification—September, 1988

Diplomate of the National Board of Medical Examiners—July, 1986

New York State license number 162479-1,
expires December 31, 1994

DEA number BG0615700

PROFESSIONAL SOCIETIES

American College of Physicians, member

New York State/County Medical Society

New York Physicians for Human Rights, President

American Association of Physicians for Human Rights, board member

PROFESSIONAL APPOINTMENTS

St. Luke's/Roosevelt Hospital,
428 West 59th Street, NY, NY 10019

St. Vincent's Hospital,
130 West 12th Street, NY, NY 10014

WORK EXPERIENCE

Present PRIVATE PRACTICE, INTERNAL MEDICINE at 285 West 11th Street, NY, NY 10014

ATTENDING PHYSICIAN,
St. Luke's/Roosevelt Hospital
and St. Vincent's Hospital

1987, Jan. to April, 1990 ATTENDING PHYSICIAN,
St. Clare's Hospital, 415 West 51st Street, NY, NY 10019

1987, Nov. to May, 1988 BELLEVUE MEDICAL CENTER,
New York, NY
Attending physician in the Department of Medicine, working at the COMMUNITY HEALTH PROJECT, a satellite clinic designed to identify and treat those at high risk for HIV-related diseases.

1987, Jan.–Sept. ST. CLARE'S HOSPITAL, New York, NY
Attending physician in the Spellman Center for the Treatment of HIV-related

Diseases, with responsibilities for inpatient and outpatient care at one of the nation's first dedicated units for HIV care.

1986, July-Dec. VETERANS ADMINISTRATION MEDICAL CENTER Brooklyn, NY
Attending Physician, Emergency Room

1978–1979 ALBERT EINSTEIN COLLEGE OF MEDICINE, Bronx, NY
Research technician, Departments of Hematology, Genetics and Parasitology

TEACHING EXPERIENCE

College of Physicians and Surgeons, Clinical Clerkship in Medicine, Course M7201, November 4–December 13, 1991

RESEARCH EXPERIENCE

"Double-Blind Study of Timunox™ (Thymopentin) in HIV-Infected Subjects," Immunobiology Research Institute, Protocol .07.32.027-92

"Open-Label Treatment With Timunox™ in HIV-Infected Patients," Immunobiology Research Institute, Protocol .07.32.008-89

"Immunobiology and Endocrine Parameters in HIV-Infected Patients," Immunobiology Research Institute, Protocol .07.30.020-92

"A Randomized Blinded Evaluation of Two Doses of Stavudine™ (2',3'-Didehydro-3'Deoxythymidine, d4T) To Make Treatment Available to Severely Immunocompromised Patients With HIV Infection Who Have Failed or are Intolerant of Alternative Antiretroviral Therapy," Bristol Myers Protocol AI455-900

"Rifabutin Therapy for the Prevention of Mycobacterium Avium Complex (MAC) in HIV-Positive Patients with CD4

Counts Less Than or Equal to 200," Adria Laboratories Treatment IND # 087085

"Open Label Oral 566C80 for the Treatment of Patients with Severe PCP Who Are Intolerant and/or Unresponsive to Therapy with Trimethoprim/Sulfamethoxaole and Parenteral Pentamidine," Burroughs Wellcome Treatment IND # 33384-10

"An Open Label Safety Study of ddC in Patients with AIDS or Advanced ARC Who Cannot Be Maintained on Zidovudine (ZDV) Therapy," Hoffman-LaRoche Protocol N3544, completed

"Treatment Program for Anemia in AIDS Patients," Ortho Biotech Protocol I88-083, completed

Treatment IND for Foscavir, Astra Treatment IND #029466, completed

"A Treatment IND Protocol for the Use of Videx™ (2',3'-Dideoxyinosine, ddI) in Patients with Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) Who Are Intolerant to Zidovudine (Retrovir™)," Bristol Myers Protocol 454-999-001, completed

"An Open Label Study Program of Videx™ (2',3'-Dideoxyinosine, ddI) in Patients With Acquired Immunodeficiency Syndrome (AIDS) Exhibiting Significant Deterioration While Taking Zidovudine (Retrovir™)," Bristol Myers Protocol 454-999-002, completed

COMMUNITY ACTIVITIES

Board of Directors, Gay Men's Health Crisis 1993 to present

Coordinator, Volunteer First-Aid Services, GMHC Morning Party, 1993

New York County Medical Society, AIDS Task Force, 1991 to present

Body Positive, board member, 1989-90

Community Research Initiative on AIDS, Physicians' Advisory Committee

ACT-UP, Treatment and Data Committee

Treatment Activist Group

American Foundation for AIDS Research (AMFAR) Scientific Advisory Board for Treatment Directory

Coalition for Rational Health Care, a coalition of community and labor groups organized to develop initiatives for HIV-positive health care workers

Hoffman-LaRoche Community Advisory Board on HIV

Burroughs-Wellcome Community Marketing Advisory Board

PUBLICATIONS

Roth EF, Grossman HA, Tanowitz H, Nagel R: Reticulocytes have increased amounts of reduced glutathione except when produced by acetyl phenylhydrazine Biochem Med June, 1979

LECTURE EXPERIENCE

Moderator, Body Positive of New York, Monthly Medical Update on AIDS

IV International Conference on AIDS: Impact on Management of HIV Disease, Roundtable sponsored by World Health Communications, Stockholm, Sweden, June 1988

"AIDS Treatment Team Workshop" World Health Communications, New York City, July 1988

Panelist, Physicians' Association for AIDS Care: Symposium on Clinical and Psychosocial Dimensions of HIV Infection, New York City, September 1988

Burroughs Wellcome Company Anti-viral Liaisons' Quarterly Meeting "Management of HIV Infection in Clinical Practice," February 1989

Body Positive of New York, "AZT Update," November, 1989

Gay Men's Health Crisis, Monthly research updates and volunteer training sessions, April 1989 to March, 1990

NYU Medical Center AIDS Medical Update Forum, January, 1990

Burroughs Wellcome physician speaker, January, 1990 to present

Ortho Biotech physician speaker, October, 1990 to present

Panelist, "100 Questions on HIV for the Amsterdam Conference," World Health Communications, April, 1992

"HIV Update, a Practitioner's Perspective," Food and Drug Administration District AIDS Coordinators' Conference, June, 1992

"Report on the Amsterdam AIDS Conference," Family Practice Grand Rounds, St. Joseph's Medical Center, Yonkers, NY, August 1992

"TPN: The New York Experience," Conference on Nutrition in HIV Disease, Munich, Germany, September, 1992

"Update on Antivirals and Opportunistic Infections," for the "VIII International Conference on AIDS Update: A Night of Truth and Hope," Palace Theater, New York, October, 1992

"AIDS, Past, Present, and Future," keynote address to the Maryland Chapter of the American Society for Parental and Enteral Nutrition Conference on Nutrition Support of the AIDS Patient, October, 1992

"The Role of Organized Physician Groups in HIV Care," Annual Statewide Conference on HIV/AIDS Policy, NYS Department of Health, AIDS Institute, Albany, NY, October, 1992

"Update from the IX International Conference on AIDS: Current Management of HIV," Marriott Marquis, New York, July, 1993

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF WILLIAM A. BARTH

William A. Barth declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am 28 years old and am a former fashion editor for a major national fashion magazine. I am single and have no children. I have always enjoyed an active and independent lifestyle.

3. I was diagnosed HIV positive in April 1992. My physician is Dr. Howard A. Grossman, a plaintiff in this action. I have been a patient of Dr. Grossman's since 1989. In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer.

4. In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. My treatment for CMV required daily three hour home infusions.

5. In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. I have experienced significant additional wasting as a result.

6. At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion.

7. In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting. I have begun to lose bowel control due to the severe diarrhea.

8. I have also suffered from microbacterium avium, a form of tuberculosis which has caused yet additional wasting, fevers and night sweats.

9. For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects.

10. I have been unable to work since September 1993 because of my severe illness. It has been recommended that I take nightly intravenous feedings to attempt to stop the wasting. While I have tolerated some such feedings, I am unwilling to accept this for an extended period of time.

11. Since I was diagnosed HIV-positive I have received medical treatment. I believe that I have received good treatment and have benefited from it. At this point, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

12. I can no longer endure the pain and suffering associated with AIDS and I want to have drugs available for the purpose of hastening my death. I want to be able to speak openly with my doctor, Howard Grossman, about intentionally hastening my death through consumption of drugs prescribed for that purpose.

13. I am mentally competent. I have no current or historical mental health problems that would impair my decision making powers regarding end of life decisions. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: September 1, 1994
New York, New York

/s/ WILLIAM A. BARTH
WILLIAM A. BARTH

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF GEORGE A. KINGSLEY

GEORGE A. KINGSLEY declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am 48 years old and am the director of Systems and Operations for a major publishing company. Prior to working in the publishing business, I was employed in supervisory positions by a major domestic and international airline for over 12 years. I received my Bachelor of Arts in English, Psychology and Business Administration from the University of Illinois and hold diplomas in various managerial courses. I am single and have no children.

3. I was diagnosed HIV-positive in the late 1980s and diagnosed with AIDS in 1993. At this time I have almost no immune system function.

4. My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. In August 1993 I was hospitalized for approximately one month to receive treatment for this infection.

5. I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. In November 1993 I was hospitalized for approximately two weeks to receive treatment for CMV.

6. I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. In December 1993 I was hospitalized for approximately three weeks to receive treatment for this infection.

7. From August 1993 to April 1994 I was unable to work because I was severely ill very frequently. Since April 1994 I have been able to return to work on a part time basis,

although my medical condition produces extreme fatigue. I live alone and I have noticed that my ability to care for myself is rapidly diminishing.

8. Several prescribed medications that I must take daily cause constant negative side effects. I take a large daily dosage of cleocin, an antibiotic prescribed to combat the toxoplasmosis infection. As a result of taking this medication I experience painful cramping, extreme gas with bloating and a total loss of appetite. I also take daily infusions of cytovene for the cytomegalovirus retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful.

9. Since I was diagnosed HIV-positive I have sought medical treatment. I believe I have received good treatment and have benefited from it. At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there is no cure for AIDS.

10. I always have believed in my ability to control my own destiny, and have made important decisions only after being guided by informed, rational thought. I value my freedom and independence above all.

11. I know what it is like to lose control over one's life because of AIDS. I have witnessed the excruciating process of dying from AIDS many times over the past several years. One of my best friends recently died after an extended period of suffering in the final stages of AIDS. This friend desired to exercise the choice of hastening his death but did not have the means to do so humanely. The sound of him crying out in pain still echoes in my memory. I could do nothing to help him and he could do nothing to help himself.

12. My informed, rational choice is that my death from AIDS, when I reach the point where there is nothing more that medical science can do to halt the advance of my disease and I am living with intolerable pain and suffering, be as swift, painless and dignified as possible. I want to be able to hasten my death in my own home, in a certain and humane way, surrounded with the people I love helping me make my passing comfortable and meaningful. I do not want my loved ones to watch me suffer needlessly.

13. I want to be able to discuss the issue of hastening my death freely and openly with my physician. It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable. While I understand that I could attempt to use over-the-counter drugs to hasten my death should my suffering become intolerable, I am horrified by the possibility that the drugs may not work effectively or completely but instead may cause additional and prolonged suffering. My purpose in seeking the advice of a physician is to be sure that I have the choice of hastening my death in the most humane and certain manner. However, I abhor the fact that discussing what I consider to be a humane act with my physician exposes him to criminal prosecution. My doctors have provided me with the best care possible and I would never do anything to jeopardize their ability to practice medicine.

14. I am mentally competent. I have no current or historical mental health problems that would impair my ability to make a rational decision regarding how to end my life.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 13, 1994
New York, New York

/s/ GEORGE A. KINGSLEY
GEORGE A. KINGSLEY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

AFFIDAVIT OF CARLA A. KERR, ESQ. WITH RESPECT TO JANE DOE AFFIDAVIT

CARLA A. KERR, ESQ. declares:

1. I am associated with the law firm of Hughes Hubbard & Reed which, along with Perkins Coie, is counsel for plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., Howard A. Grossman, M.D., Jane Doe, George A. Kingsley, and William A. Barth in the above-captioned action. I am duly admitted to practice before this Court and am fully familiar with the facts and circumstances surrounding this action.

2. I submit this affidavit for the purpose of providing the Court with a redacted copy of the Declaration of Jane Doe, attached as Exhibit A. Plaintiff Jane Doe was a terminally ill, competent adult who died as a result of throat cancer subsequent to the commencement of this action. Ms. Doe's signature, in her true name, has been redacted from the Court's copy of the declaration to preserve her privacy. The original signed declaration is maintained in the law offices of Hughes Hubbard & Reed.

/s/ CARLA A. KERR
CARLA A. KERR

Sworn to me before this
16th day of September, 1994

/s/ BARBARA S. ADLER
Notary Public

BARBARA S. ADLER
Notary Public, State of New York
No. 31-4748551
Qualified in New York County
Commission Expires Feb. 28, 1996

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)
Received September 15, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF JANE DOE

JANE DOE declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. Jane Doe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 76 years old and am a retired physical education instructor. I received my degree in physical education from New York University in 1939. I also hold a Masters Degree in High School Guidance Counseling, which I earned from Queens College during the 1960s while I worked and cared for my children. I am widowed and have two grown children. I have always enjoyed an active and independent lifestyle. I have been a leader in my current retirement group school program and active in civic affairs.

4. In 1988 I was diagnosed with thyroid cancer. I underwent surgery to remove my thyroid, a portion of my jugular vein, and strap muscles in my right neck. I also had a 1/4 laryngectomy, leaving my voice weak but intact. I subsequently received iodine radiation therapy.

5. For several years my cancer was in remission. However, in late 1993 I was diagnosed with a major recurrence. I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural cavity and it is painful to yawn or cough.

6. My physicians have advised me that only palliative medical options are available to me and that no curative medical options are available. My physicians have suggested that one palliative procedure would be a complete laryngectomy, the surgical lifting of my stomach, and removal of my carotid

artery. This procedure would entirely and permanently eliminate my ability to speak, and the prognosis for recovery from it would be poor.

7. Because the tumor causes extreme difficulty in swallowing, I am constantly choking on my own saliva and mucous. At this time, I can no longer swallow sufficient food to nourish myself. It was recently recommended that I have a feeding tube surgically implanted into my stomach through which to receive nutrition and hydration. In early July 1994 I had the tube implanted and have suffered serious problems as a result. I have not tolerated the tube feeding well.

8. The pain associated with this cancer is constant, especially in my neck, where the pressure and ache are continuous. I experience very sharp pain around my diaphragm each time I take deep breaths, cough, belch or yawn.

9. I take a variety of medications to manage the pain. I attempt to take enough medication so as to alleviate the pain while still retaining an alert mental state. It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state.

10. I have experienced a variety of adverse side effects with each treatment regimen, including i) terrible scarring inside my throat and neck from surgery and radioactive iodine; ii) burning and swelling in my neck, a hoarse voice and nausea from beam radiation; and iii) severe pain, vomiting, nausea and pressure associated with the tube feeding.

11. I have pursued medical treatment since the time my cancer was originally diagnosed to the present time. I believe that I have received the currently available conventional treatment and have benefited from some of it. At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

12. At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

13. For all of my adult life I have held the belief that extending human suffering in the case of terminal illness is inhumane, uncivilized and cruel, since we have the technology to allow people to choose to die in a humane manner. I believe it is my right to die peacefully and comfortably when I am terminally ill and suffering intolerably. I believe it is partly religious freedom and partly the pursuit of liberty and happiness guaranteed me by the United States Constitution. I have always considered freedom to choose how and when to die a most important human right for the terminally ill.

14. People should not be asked against their will to suffer unnecessarily in the process of dying when medical science could provide a humane death. To withhold such choice, and the means to exercise it, from those who are suffering is to deny me my right to live and die humanely. I see it as unnecessarily cruel and inhumane to deny me this option. It also is inhumane to my loved ones, my family, to require them to watch helplessly as I am forced to endure such suffering.

15. I was able to put two of my dogs to rest when they were suffering from painful, incurable diseases and yet I do not, as a conscious and competent adult, have the freedom to opt for the same humane end to my life. This is wrong.

16. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 28 day of July, 1994.

_____

A/K/A Jane Doe

[EXCERPTS]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TG)

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL,

Defendant.

DEFENDANT'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION AND IN SUPPORT OF CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

G. OLIVER KOPPELL
Attorney General of the
State of New York
120 Broadway–24th Floor
New York, NY 10271
(212) 416-8570

MICHAEL S. POPKIN
Assistant Attorney General
Of Counsel

JAY T. WEINSTEIN
Legal Assistant

* * *

and Supp. 1994).[5] The current laws classify assisted suicide under section 125.15(3) as manslaughter in the second, instead of the first degree, and treat "promoting a suicide attempt" as a class E felony. N.Y. Penal Law § 120.30 (McKinney 1987).[6]

C. The New York Task Force on Life And The Law

The New York Task Force on Life and the Law ("Task Force"), convened in 1985 by Governor Mario Cuomo and consisting of members from diverse backgrounds and viewpoints, has conducted a study of New York's prohibition of physician-assisted suicide for the terminally ill, and recommended *against* changing the laws with respect to this conduct. The New York State Task Force On Life And The Law, *When Death Is Sought: Assisted Suicide And Euthanasia In The Medical Context*, May 1994, at 117-48 (hereinafter "Task Force Report"). In the past, the Task Force's recommendations concerning the right to decide about medical treatment have been enacted into law. *See* New York Public Health Law

---

5 The New York State Court of Appeals recently held that an individual who aids or urges another to a successful suicide can also be found guilty of second degree manslaughter under N.Y. Penal Law § 125.15 (1), for recklessly causing another's death. *People v. Duffy*, 79 N.Y.2d 611, ___ N.Y.S.2d ___ (1992).

6 The Temporary State Commission on Revision of the Penal Law and Criminal Code, which, in 1965, introduced to the legislature the current form of New York's penal law, removed the "more sympathetic cases" of assisted suicide from the ambit of "murder," and placed within the category of second degree manslaughter instances of "assistance rendered at the request of a person tortured by painful disease." Temporary State Commission on Revision of the Penal Law and Criminal Code, Proposed New York Penal Law to the Legis. Session of 1964, at 339 (1964). The practice commentary to the current re-enactment of the penal law in fact includes a hypothetical of assisted suicide that would constitute second degree manslaughter: "a man who, upon the plea of his incurably ill wife, brings her a lethal drug in order to aid her in ending a tortuous existence . . ." Practice Commentary to N.Y. Penal Law § 125.15(3) (McKinney 1975) (by A. Hechtman).

Articles 29-B (Orders Not To Resuscitate) and 29-C (Health Care Agents and Proxies). *See* Task Force Report at vii. The Task Fore compiled extensive data regarding suicide and the terminally ill.

The Task Force found that allowing physician-assisted suicide or euthanasia[7] would expose significant segments of the population, especially those already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group, to "extraordinary risks." Task Force Report, Preface at vii-viii, and Ch. 6. It noted the statistical correlation between requests for assisted suicide and depression, as well as requests for assisted suicide and poorly controlled pain, and concluded that allowing assisted suicide would result in an increased number of suicides in individuals in both these categories suffering from treatable symptoms. *Id.* Other individuals, such as those who felt that they were a burden on their families, would also be likely to choose suicide. The Task Force recognized that suicide advocates posited ideal cases in which none of these conditions were present, and in which the physicians had long term relationships with their patients, but found that these ideal cases

* * *

[7] Physicians assist another in committing suicide when, for example, they provide a patient with a lethal dose of pills which the patient then self-administers. By contrast, euthanasia occurs when physicians themselves administer the lethal drug, an act of murder. *See* N.Y. Penal Law § 125.25(1). *See also*, Report of N.Y. Task Force, at 63-64. As numerous commentators have noted, the line between assisted suicide and euthanasia is far from bright.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Received October 12, 1994

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,

Defendant.

NOTICE OF CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

PLEASE TAKE NOTICE that, upon all the pleadings and proceedings in this matter, defendants will move this Court, before the Honorable Thomas P. Griesa, United States District Judge, at the Courthouse, Foley Square, New York, New York, on October 14, 1994 at 10:30 in the forenoon, or as soon thereafter as counsel may be heard, for an Order pursuant to Rule 12(c) of the Federal Rules of Civil Procedure granting them judgment on the pleadings, for the reasons set

forth in defendants' Memorandum of Law of even date with this cross-motion.

Dated: October 7, 1994

G. OLIVER KOPPELL
Attorney General of the State
of New York,

By: /s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)
SUSAN L. WATSON (SW 0023)
Assistant Attorneys General
Of Counsel
NYS Department of Law
120 Broadway–24th floor
New York, NY 10271
(212) 416-8570

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D. HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants,

Kathryn L. Tucker
Perkins Coie
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and, to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients tc self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

4. The proposition that the withdrawal of medical treatment does not require full, conscious and active participation by the terminally ill patient's doctor is not accurate. The removal of a life support system that directly results in the patient's death requires the direct involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments.

5. For example, sometimes patients with lung cancer or other terminal respiratory diseases are put on respirators (breathing machines) in an effort to prolong their life. Some of these patients decide that they no longer want to go on living if they must remain on such machines to breathe, or because other aspects of their suffering have become intolerable. Once they are fully informed of their alternatives, and are sure that they want the respirator removed even if it will result in their death, they then have the right to have the treatment discontinued. At a practical level, the doctor must take several actions to carry out the patient's desire. The doctor must turn off the breathing machine, disconnect the machine from the tube that goes to the patient's lungs, and then remove the tube from the patient's lungs. Since dying of respiratory failure can be one of the most excruciating and frightening deaths possible, the doctor usually must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation. These patients must be carefully monitored after the respirator is withdrawn, for sometimes the symptoms of severe air hunger reemerge in spite of continuous infusions of morphine or barbiturates. These medications must often be used in doses that contribute to the patient's death by suppressing their respiratory drive. Such patients can linger for days or even weeks in a twilight state, with fluctuating levels of mental alertness and of air hunger, before eventually dying. The removal of a mechanical ventilator requires active participation and ongoing monitoring by the doctor and other members of the health care team. In spite of everyone's best efforts, it can result in a wrenching experience for the patient, the patient's family and medical personnel.

6. Some dying patients are dependent on feeding tubes or intravenous lines to provide hydration and nutrition. These patients have the right to refuse this treatment even when it will result in their death. Though some patients find discontinuing hydration and nutrition an acceptable way to die, others experience the subsequent process of gradually dehydrating, starving, and passing into an unconscious, completely dependent and helpless state both humiliating and unacceptable. The process generally takes seven to ten days, though it may take much longer if the patient takes sips of any kind of liquids. The patient gradually loses control of his or her men-

tal and physical capacities, and becomes totally dependent on medical personnel and family to care for even the most basic bodily functions. The patient's kidneys and liver eventually fail, allowing the accumulation of toxins that gradually cloud consciousness, and eventually result in the patient's death. As patients pass through this process, they continue to need the active involvement of their physicians and other medical personnel. Patients whose organs are failing may experience hallucinations, fear and confusion. Such symptoms must be treated, often with sedatives that may hasten the patient's death. Under these circumstances, sedatives must be used because doctors must not let their dying patients linger in a nightmarish condition that can only end in their death. While death from dehydration and starvation is acceptable to some of our patients, others ask us why they must endure such an ordeal when it can only end in their death, especially when there are alternatives available that could ease death more humanely.

7. Though deaths such as those described above have been characterized as "natural," they actually involve the active participation of doctors throughout the process, often including medical interventions that contribute to an earlier death. As the clinical descriptions suggest, these processes are often not an easy way out. Yet, at least these patients who are dependent on life-sustaining treatment are allowed to have a legitimate, open discussion with their physician about choosing death as preferable to life under the circumstances they are forced to live, and their physicians are allowed to actively and openly assist them to die without fear of legal repercussions. Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.

These patients are asking us, and at times begging us, for the same choice.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF SAMUEL C. KLAGSBRUN, M. D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF HOWARD A. GROSSMAN, M. D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and, to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker (KT9200)
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099

Carla A. Kerr (CK5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF JACK FROOM, M. D.

Jack Froom, M.D. declares:

1. I am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Illinois in 1946.

3. My specialty is Family Practice. I am certified by the American Board of Family Practice and have over 20 years experience practicing medicine in a clinical setting as a family physician. I am also a Professor of Family Medicine and have over 20 years of teaching experience in that field. I am presently Professor at the State University of New York at Stony Brook. From 1978 through 1991 I was the Director of Family Medicine Research at this University.

4. I serve on the editorial advisory board or am manuscript consultant to numerous medical journals including: Family Practice: An International Journal; Annals Of Internal Medicine; Pediatrics; Journal of American Diseases of Children; Journal of the American Board of Family Practice; Journal of Family Practice; Family Medicine; and Archives of General Psychiatry.

5. I hold hospital appointment privileges and am a Senior Attending Physician at University Hospital, Stony Brook, New York.

6. I have published over 80 articles related to the practice of Family Medicine in medical journals. I have also authored numerous books, book chapters and monographs in the field.

7. I have substantial experience and have conducted research and published in the area of detecting depression in primary care patients. Of particular relevance here are "Detection of Major Depressive Disorder in Primary Care Patients," 6 *Journal American Board of Family Practice* 5

(1993), "The Inventory to Diagnose Depression (IDD) in Primary Care Patients," 10 *Family Practice* 312 (1993).

8. My complete curriculum vitae is attached hereto.

9. In my nearly 50 years experience as a practicing family physician and medical educator, I have had many occasions to witness mentally competent, terminally ill adult patients confront issues relating to their dying process, including the issue of hastening the dying process. Over this period, I have also seen many patients endure unnecessarily prolonged pain and suffering in the dying process under circumstances where patients, for one reason or another, had insufficient participation in deciding upon their terminal care.

10. Physicians caring for patients with terminal illnesses necessarily become directly involved in assisting such patients and their families to understand the prognosis, expected course and options for either therapeutic or palliative care. In the presence of terminal illness, the shared goal of medical care at some point becomes comfort care rather than cure. The physician's task becomes one of alleviating pain and suffering as much as possible.

11. With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt. As a result, many experience prolonged deaths often involving pain, suffering and loss of dignity. In reaction to this problem, an increasing number of patients want more direct control over the type of care they receive in the last stage of their lives. A subset of dying patients desire to shorten their dying process and thereby avoid a lingering death and associated pain, suffering and loss of dignity.

12. The desire of a patient to shorten the dying process is not necessarily indicative of depression or any other form of mental illness or instability. This choice can be entirely rational in light of a particular patient's condition, prognosis and suffering. Physicians can determine whether a patient's

request to hasten death is rational and competent or motivated by depression or other mental illness or instability. Physicians currently make these determinations as to patient capacity to make end-of-life decisions with respect to orders not to resuscitate and refusal of life-sustaining treatment.

13. Terminally ill persons who seek to hasten death by consuming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. Many terminally ill persons will be taking a variety of medications for their condition; for example, patients suffering chronic pain may be taking high doses of morphine or other narcotics and may have developed a high tolerance to narcotics. Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task.

14. Physician assistance for terminally ill patients suffering unrelievable and intolerable pain and physical decline comports with a physician's ethical obligation to alleviate needless, painful suffering.

15. It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. These efforts are often unsuccessful and can cause the patient and family increased anxiety, pain and suffering. Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

16. There is often a severe adverse emotional and psychological effect on terminally ill patients who either are unable to broach the subject of their desire to hasten their death with their physician because of the current prohibition or broach the subject but are rebuffed. These patients feel abandoned by their physician when most in need of help.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Stony Brook
this 8 day of October, 1994.

/s/ JACK FROOM, M.D.
JACK FROOM, M.D.

DECEMBER 1993

CURRICULUM VITAE

Jack Froom, M.D.
Professor of Family Medicine
Health Sciences Center
State University of New York at Stony Brook
Stony Brook, NY 11794

Phone: (516) 444-2300

Birthplace: Chicago, Illinois
Date of Birth: 5/17/23

Social Security Number: 335-16-3431

Married - Spouse's Name: Selma B. Froom
Year of Birth of Children: 1948, 1951, 1953, 1960

United States Military Service: Rank - Captain, Air Force
1943-1949

EDUCATION

University of Illinois - Urbana, Illinois - Premedical - B.S. Degree - 1945

University of Illinois - Chicago, Illinois - Medicine - M.D. Degree - 1946

POSTDOCTORAL TRAINING

Los Angeles County Hospital - Rotating Internship - 1946-1947

Langley Porter, San Francisco - Trainee - Psychiatry - 36 weeks - 1962

SPECIALTY BOARD

American Board of Family Practice - 1970
Recertification 1977, 1982, 1988

PRIVATE PRACTICE

1950-1971 - Petaluma, California
Past PresidentvSonoma County Heart Association
Past Chief of Staff - Sonoma County Hospital, Santa Rosa, California
Past Chief of Staff - Hillcrest Hospital - Petaluma, California
Director, Coronary Care Unit - Hillcrest Hospital - 1967-1971

UNIVERSITY OF ROCHESTER - 1971 - 1978

Assistant Professor of Family Medicine 1971 - 1974
Associate Professor of Family Medicine 1974 - 1978

STATE UNIVERSITY OF NEW YORK AT STONY BROOK
1978 - PRESENT

Professor
Vice Chairman 1978 -1991
Director of Family Medicine Research 1978 -1991

PROFESSIONAL ACTIVITIES

International

Chairman, Classification Committee - U.S. representative — World Organization of National Colleges Academies and Academic Associations of General Practitioners - Family Physicians (WONCA) 1976-1991.

WONCA Representative - ICD-10 Revision Meeting, Geneva, 1989

Chairman, Sub-committee on Standard Terminology -World Organization of National Colleges, Academies and Academic Associations of General Practitioners -Family Physicians

Coordinator - International Primary Care Network (IPCN) includes U.S.A., Canada, Australia, New Zealand, United Kingdom, Israel, Netherlands, Belgium, Switzerland

National

Former Chairman, Advisory Committee to the International Classification of Diseases — Adapted — American Hospital Association

Chairman, Committee for the Development of Glossary of Definitions of Primary Care — North American Primary Care Research Group

Member Process Coding Committee — North American Primary Care Research Group

Ad Hoc Committee to produce a Position Paper on Research in Family Medicine — Society of Teachers of Family Medicine

Board of Directors — The Ambulatory Sentinel Practice Project of North America
Board of Directors — Hames Consortium

State

Chairman, Committee of Research, Directors of New York State Family Medicine Programs 1978-1980.

Health Advisory Resources Committee — New York State Department of Correctional Services 1974-1980.

Medical Journals

Former Editor - WONCA News
Editorial Advisory Board
Family Practice: An International Journal
Manuscript Consultant:
Annals of Internal Medicine
Pediatrics
Journal of American Diseases of Children
Journal American Board of Family Practice
Journal of Family Practice
Family Medicine
Archives of General Psychiatry

Editor - in Family Practice: Selections from the Current Literature 1987 - 1991

Editor - WONCA NEWS 1987 - March 1988

Federal Agencies

Consultant to Ambulatory Care, Long-term Care, and Manpower Facilities Technical Consultant Panel of the HEW National Committee of Health and Vital Statistics

Invited participant conference on the Accuracy of Abstracted Patient Discharge Data - National Center for Health Statistics

Invited participant conference on Uniform Hospital Discharge Diagnostic Summary Coding Guidelines

National Institute of Mental Health Services Research Review Committee 1987-1991

Invited participant: National Institute of Mental Health Conference on DSM 4. July 1989, Jan 1990

Invited participant: Fourth Annual NIMH International Research Conference on Classification and Treatment of Mental Disorders in General Medical Setting June 1990

Consultant - AHCPR Panel on Depression, 1991

Stony Brook University

Professor of Family Medicine 1978 - Present

Vice Chairman Department of Family Medicine 1978-1991
Chairman Medical Records Committee, University Hospital 1981 - 1985
Director of Research, Department of Family Medicine 1978 - 1991
Chairman, AP&T Committee, Department of Family Medicine 1978 - 1991
Curriculum Committee, Medical School 1984 - 1988

Appointment, Promotion and Tenure Committee - 1990 - Present
Director, Third Year Clerkship in Family Medicine, University Hospital 1981 - 1987
Ad Hoc Committee on Use of Media, Medical School, 1981
Search Committee for Chairman, Department of Psychiatry
Search Committee for Chairman, Department of Pediatrics
Co-Teacher — Literature in Medicine
Teacher in a full range of courses including:
Lectures in 3rd year clerkship
Lectures in 2nd year systems courses
Lectures in yearly continuing education courses
Lectures in noon conferences
Monthly lectures in electrocardiography

HOSPITAL APPOINTMENT

Senior attending University Hospital, Stony Brook, New York

RESEARCH ACTIVITY - CURRENT

1. Classification and nomenclature of family/household problems
2. Otitis Media - International Comparisons
3. Computerized program for surveillance of hypertension patients
4. Diabetes Mellitus - type 2 - surveillance
5. Functional status assessment
6. Study of the process of ambulatory care
7. Depression and Seasonality in Primary Care Patients

PUBLICATIONS

1. *Munib HI,Froom J*: Rupture of a duodenal ulcer during cortical extract therapy for serum sickness. California State Medical Journal 94:378-379, 1962.

2. *Froom J*: Conversion to problem-oriented records in an established practice. Annals of Internal Medicine 78:254:275, 1973.

3. *Froom J, Rozzi C, Metcalfe D*: Computer Analysis of morbidity reports in primary care. Journal of Clinical Computing 2:42-51, 1973.

4. *Farley E, Treat D, Baker C, Froom J, Henck S*: An integrated system for the recording and retrieval of medical data in a primary care setting (Introduction to Series); Part 1. The age sex register. Journal of Family Practice 1:1:45–46, 1974.

5. *Froom J*: Part 2: Classification of diseases. Journal of Family Practice 1:1:47-48, May 1974.

6. *Froom J*: Part 3: Diagnostic Index-E Book. Journal of Family Practice 1:2:45-48, August 1974.

7. *Froom J*: Part 4: Family folders. Journal of Family Practice 1:2:49-51, August 1974.

8. *Froom J*: Part 6: The problem-oriented record. Journal of Family Practice 1:3/4:45-52, November/December 1974.

9. *Froom J*: Part 7: The encounter form and the minimum basic data set. Journal of Family Practice 2:1:37-41, February 1975.

10. *Froom J, Treat D, Farley E. Henck S*: A curriculum for family medicine. NY State Journal of Medicine 74:15511553, August 1974.

11. *Henk M, Froom J*: Outreach by primary care physicians. Journal of the American Medical Association 233:256-259, 1975.

12. *Froom J*: A new classification of health problems for primary care physicians (The ICHPPC) Journal of Clinical Computing 2:76-82, 1976.

13. *Froom J*: The International Classification of Health Problems for Primary Care. Medical Care: 5:459-463; May 1976.

14. *Froom J*: Assessment of quality of care by profiles of physicians' morbidity data. Journal of Family Practice Vol 3:3:301-303, 1976.

15. *Froom J*: Minimum basic data set. New York State Journal of Medicine: Vol 76:9:1541 - 1542, September 1976.

16. *Trabert NL, Froom J, et al;* Physicians prescribing patterns: I. Technical aspects and initial analyses. Drug Information Journal: April - September 1976: 84-90.

17. *Sullivan RJ, Froom J, Wood M, Williams T*: Primary care practice assessment and information systems. Johnson Foundation. December 1976.

18. *Froom J, Warren P, Mangone D, et al*: Implementation of a medical record and data system for correctional facilities. New York State Journal of Medicine. February 77:2:209-215.

19. *Froom J, Howe, Mangone D, et al*: A health data system for New York State correctional facilities. American Journal of Public Health Brief. March 1977:67:3:250-251.

20. *Froom J*: Lead screening by family physicians. Journal of Family Practice 4:4:631–633, 1977.

21. *Farley E, Treat D, Froom J, et al*: An integrated medical record and data system for primary care. (Introduction to eight-part series) Journal of Family Practice 4:5:949, 1977.

22. *Froom J*: Part 1: The age sex register: Definition of the patient population . Journal of Family Practice Vol. 4:5:951-953, 1977.

23. *Froom J*: Part 2: Classifications of health problems for use by family physicians. Journal of Family Practice Vol. 4:6:1149-1151, 1977.

24. *Froom J, Culpepper L, Boisseau V*: Part 3: The diagnostic index—manual and computer methods and applications. Journal of Family Practice Vol. 5:1:113-120, 1977.

25. *Froom J, Culpepper L, Kirkwood CR, Boisseau V, Mangone D*: Part 4: Family information. Journal of Family Practice Vol. 5:2:265-270, 1977.

26. *Farley ES,m Boisseau V, Froom J*: An integrated medical record and data system for primary care: Part 5: Implications of filing family folders by area of residence. Journal of Family Practice 5:3:427-432, 1977.

27. *Froom J*: Problem oriented medical records: A reassessment. Journal of Family Practice Vol.5:4:627-630, 1977.

28. *Froom J, Kirkwood CR,Culpepper L, Boisseau V*: An integrated medical record and data system for primary care; Part 7: The encounter form: problems and prospects for a universal type. Journal of Family Practice Vol. 5:5:845-849, 1977.

29. A Glossary for Primary Care: Report of the North American Primary Care Research Group (NAPCRG) Committee on Standard Terminology — Froom J, Chairman, Journal of Family Practice 5:4:633-638, 1977.

30. *Kirkwood CR, Froom J*: Screening during routine health assessment. Journal of Family Practice 5:4:561-566, 1977.

31. *Schneeweiss R, Stuart W, Froom J, et al*: A conversion of the *Royal College of General Practitioners Classification of Diseases Modified* for use with problem oriented medical records (RCGP) to the *International Classification of Health Problems in Primary Care* (ICHPPC). Journal of Family Practice 5:3:415-424, 1977.

32. *Howe B, Froom J, Culpepper L, et al*: Adoption of the sick role by prisoners: Report on a multifunctional experiment. Social Science and Medicine Vol. 11:507-510, 1977 Perfamon Press.

33. *Boisseau V, Froom J*: Practice profiles in evaluating the clinical experience of family medicinal trainees. Journal of Family Practice Vol. 6:801-805, 1978.

34. *Froom J, Culpepper L, Becker L, Boisseau V*: Research design in family medicine. Journal of Family Practice 7:75-90, 1978.

35. *Froom J, Boisseau V, Sherman*: Selective screening for lead poisoning in an urban teaching practice. Journal of Family Practice 9:856-70, 1979.

36. *Froom J, Boisseau V*: Benzdamine oral rinse for sore throat. Current Therapeutic Research 26:856-861, 1979.

37. *Froom J, Rosen MG*: The family in family medicine research. Journal of Medical Education 55:60-621, 1979.

38. *Jolly W, Froom J, Rosen MG*: The genogram. Journal of Family Practice Vol. 10:251-255, 1980.

39. *Froom J, Mold J, Culpepper L, Boisseau V*: The spectrum of otitis media in family practice. Journal of Family Practice 10:599-605, 1980.

40. *Boom WH, Lamberts HE, Froom J, Blondell R*: Patient and family doctor. Rochester USA, and Ommord (Netherlands) compared. (1978) Huisarts Wetenchap 21:53.

41. *Froom J*: The spectrum of urinary tract infections in family practice. Journal of Family Practice 11:385-391, 1980.

42. *Froom J, Schneeweiss R*: Use of the international classification of health problems in primary care (ICHPPC-2) for reimbursement. Journal of Family Practice 11:609-620, 1980.

43. *Culpepper L, Froom J*: Incarceration and blood pressure. Social Science and Medicine 14A:571-574, 1980.

44. Graduates of Family Practice Residency Programs in New York State. Report of a committee of directors of research of New York State Family Medicine Residency Programs. *Jack Froom, M.D.*, Chairman, Journal of Family Practice 11:753-760.

45. *Tindall HL, Culpepper L, Froom J, et al*: The NAPCRG process classification for primary care. Journal of Family Practice 12:309-318, 1981.

46. *Becker LA, Boyle RM, Froom J, et al*: A Conversion Code for ICHPPC-1 to ICHPPC-2, Journal of Family Practice 12:707-719, 1981.

47. *Froom J, Tchao P*: A curriculum in electrocardiography for family physicians. Journal of Family Practice 12:857-864, 1981.

48. *Froom J (Editor)*: An International Glossary for Primary Care. Report of the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioner/Family Physician (WONCA). Journal of Family Practice 13:671-681, 1981. Also published in Huisarts en Wetenchap 24:342-346, 1981.

49. *Froom J, et al*: (Committee Member). Meeting the Challenge of Research in Family Medicine. Report of a study group on Family Medicine Research. Journal of Family Practice 14:105-113, 1982.

50. *Froom J*: Otitis Media. Journal of Family Practice 15:743-770, 1982.

51. *Armstrong EG, Jaffe A, Froom J, Rosen M*: Development of a clerkship curriculum in the family life cycle. Journal of Medical Education 57:872-874, 1982.

52. *Froom J*: New directions in standard terminology and classification in Primary Care. Public Health Reports 99:73-77, 1984.

53. *Froom J, Feinbloom RI, Rosen MG*: Risks of Referral. Journal of Family Practice 18:623-626, 1984.

54. *Froom J*: Diabetes Mellitus — A Review: Family Practice — An International Journal 1:52-66, 1984.

55. *Jaffe A, Armstrong EG, Robbins AC, Froom J*: A Comprehensive Clerkship in family medicine. Medical Education 18:28-32, 1984.

56. *Green LA, Wood M, Becker L, Farley ES, Freeman WL, Froom J, et al*: The ambulatory sentinel practice network: Purpose, methods and policies. Journal of Family Practice 18:275-280,1984.

57. *Froom J, Froom P*: Electrocardiogram abnormalities in primary care patients. Journal of Family Practice 18:223-225, 1984.

58. *Froom J*: Family Practice — A unique discipline., Israel Journal of Medical Sciences 20:59

59. *Reis S, Almagor G, Froom J*: Pediatric health care within the family medicine framework. Harofah 277-279 March 15, 1984 (Hebrew).

60. *Froom J*: ICHPPC-2-Defined (International Classification of Health Problems in Primary Care). Journal of Family Practice 19:129-130,

61. *Froom P, Froom J, Van Dyk D et al*: Lytic Spondylolisthesis in Helicopter Pilots Aviation, Space and Environmental Medicine. 55:556-557, 1984.

62. *Froom J*: (Member Family Physicians Hypertensive Study Group) A multicenter comparison of the antihypertensive effects of atenolol and chlorthalidone given alone and in combination. Current Therapeutic Research 35:31-39, 1984.

63. *Froom J*: Headache: The effect of household Configuration (Special Feature.) Australian Family Physician 1985: 14:956-959.

64. *Schneeweiss R, Cherkin DC, Hart LG, Revicki DA, Wollstadt LJ, Stephenson MJ, Froom J, Dunn EV, Tindall HL, Rosenblatt RA:* Diagnosis Clusters Adapted for ICD-9-CM and ICHPPC-2. J Fam Pract. 1986 22:69-72.

65. *Froom J*: Royal College of General Practitioners Classification 1984. A review. Family Practice (WONCA News) 1985:2.

66. *Froom P, Gross M, Froom J, et al*: Factors associated with micohematuria in asymptomatic young men. Clin Chem 32:2013-2015, 1986.

67. *Froom J*: International electronic mail. International Medical Practice Newsletter 6:5, 1986.

68. *Froom P, Froom J*: Adjusting for selection biases in referral populations. Journal of Family Practice 24:80-82, 1987.

69. Ad Hoc Working Group for Critical Appraisal of the Medical Literature (Froom J. - Members): A proposal for more informative abstracts of clinical articles. Annals of Internal Medicine 1987; 106:598-604.

70. *Froom J, Yodfat Y*: Classifying Family/Household Problems. Family Practice 1987; 4:111-113.

71. *Froom P, Gross M, Froom J, Margoliot S, Benbossat J*: Sensitivity of the high-power field method in detecting red blood cells in the urinary sediment. Israel Journal of Medical Science 1987; 23:1118-11120.

72. *Culpepper L, Froom J*: The International Primary Care Network: Purpose, Methods and Policies. Family Medicine 1988;20:191-201

73. *Froom J et al*: Diagnosis and antibiotic treatment of acute otitis media. Report from International Primary Care Network. Brit Med J 1990;300:582-6

74. *Froom J*: Glycemic control in elderly people. Clin in Geriatric Medicine. 1990; 6:933-941.

75. *Froom J*: Disease-specific functional status assessment. In Functional Status Measurement in Primary Care: WONCA Classification Committee (Froom J. Chairman) Springer Verlag-New York 1990:p66-71.

76. *Froom J etal*: Otitis Media in day care children. J Fam Pract. 1991; 32-289-294

77. *From J, Froom P*: Prudence in disease prevention. J Clin Epidemiol. 1991;44:112-1130

78. *FroomJ,Schlager D, Stenecker S, Jaffe A*: Detection of Major Depressive Disorder in Primary Care Patients. Journal American Board of Family Practice 1993:6; 5-11.

79. *Froom P, Froom J*: Selection Bias in Using Data From One Population to Another: Common Pitfall in the Interpretation of Medical Literature. Theoretical Medicine 1992:13; 255-259.

80. *Shavartizman P, Froom J*: Need for Continuing Tuberculosis Surveillance in Previously Screened New Immigrants. Journal American Board of Family Practice 1993:6, 61-63.

81. Froom P, *Froom J*. Deficiencies is structured medical abstracts. J Clinical Epidemiol. 1993;46:591-594.

82. *Froom J*, Hermoni D. The inventory to diagnose depression (IDD) in primary care patients. Fam Pract. 1993;10:312-316.

83. Herman J, *Froom J*. Thrombolytic therapy in acute myocardial infarction; some reservations. J Clinical Epidemiol. 1993;46:1237-1241.

84. *Froom J*, Culpepper L etal. Effect of patient characteristics and disease manifestations on the outcome of acute otitis media at two months. Arch Fam Med. 1993;2:841-846.

85. Culpepper L, *Froom J etal*. Otitis media in adults. J Amer Board Fam Pract. 1993;6:333-339.

86. Becker LA, Green LA, Beufait D, Kirk J, *Froom J*. Detection of intracranial tumor, subarachnoid hemorrhage or subdural hematoma in primary care patients. J Fam Pract. 1993;37:135-141.

87. Becker LA, Green LA, Beufait D, Kirk J, *Froom J*. Use of CT scans for the investigation of headache. J Fam Pract. 1993;37:129-134.

88. Herman J, *Froom J*. Marital status and timing of coronary artery surgery. Med Hypothesis. 1994;41:459-461.

In Press

1. Tsuda T, Aoyama H, Froom J. Primary health care in Japan and the United States. Soc Sci and Med.

Submitted

1. Schlager D, *Froom J*, Jaffe A, Steneker S. Wintertime depression and functional impairment among primary care patients. Psychosomatic Medicine.
2. Jaffe A, Froom J, Galambos N. Minor depression in primary care. JAMA

Series In Family Practice

Froom J: Selections from Current Literature Family Practice

1. 1987; 4:152-154
2. 1987; 4:240-243
3. Back Pain 1987; 4:330-334
4. Diabetes Mellitus Update 1988; 5:68-74
5. Symptoms of Undetermined Etiology 1988; 5:224-228
6. Review Articles 1989; 6:70-73
7. Health Status Assessment 1989; 6:153-156
8. The Cholesterol Controversy 1989; 6:232-237
9. Fibrositis. 1989; 6:316-319
10. Euthanasia. 1991; 8: 100-104
11. Hormone Therapy in Postmenopausal Women. 1991;8:288-292.

PUBLISHED PROCEEDINGS

1. *Froom J*: Design of Curriculum based on morbidity data. Society of Teachers of Family Medicine, Washington, D.C. 1973.
2. *Treat D, Froom J*: The International Classification of Health Problems in Primary Care. Proceedings of the Fourth Annual Conference of the Society for Computer Medicine, New Orleans, Louisiana, November 7-10, 1974.
3. *Froom J*: Quality of Care Assessment by Profiles of Physicians' Morbidity and Prescription Data. Delivered at the World Organization of National Colleges and Academies of General Practice/Family Medicine - November 6, 1974, Mexico City.
4. *Froom J*: Practice Profiles in the Family Practice Center - Computer Method. Annual Workshop for Directors of Family Practice Residencies - American Academy of Family Physicians, June 1975, Kansas City, Missouri.
5. *Froom J*: The International Classification of Health Problems for Primary Care-Cornerstone of an Ambulatory Data Set. Delivered at the Fifth Annual Conference of the Society for Computer Medicine, Chicago, Illinois, November 12-14, 1975.
6. *Jolly W, Froom J, Rosen M*: The Genogram in Primary Care Research in 1980. Ed. Lipkin J, White KL.

BOOKS

1. Lipkin M, Bufford J, Froom J, White KL: Primary Care Research in 1981. The Rockefeller Foundation.
2. Lipkin M, Bufford J, Froom J, Schonberg K, White KL: Primary Care Research in 1982. New York University.
3. Lipkin M, Bufford J, Froom J, et al: Primary Care Research in 1983. New York University Press 1984.

4. Froom J: Non-Insulin-Dependent Diabetes Mellitus. Saunders - Primary Care 1988.
5. Froom J: Diabetes Mellitus in Elderly Patients. Saunders. Clinics in Geriatric Medicine - Due Nov. 1990
6. WONCA Classification Committee. J. Froom, Chairman Functional Status Measurement in Primary Care - Springer Verlag - 1990

Chapters

1. Chronic Childhood Illness, Assessment of Outcome. Grave GD, and Pless IB (eds.): Fogarty International Center Series on the Teaching of Preventive Medicine; DHEW Publication No., (NIH)-76-876, Washington, D.C. 1976.
2. Acute Back Pain - Passive Treatment in Common Dilemmas in Family Medicine by John Fry. George A. Bogden & Son, New Jersey, 1983.
3. Classification Systems in Family Medicine by Robert B. Taylor. Springer Verlag - New York 1983.

Contributions to Classifications

1. ICHPPC - World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. American Hospital Association 1975. Froom - U.S. Representative.
2. ICHPPC-2 World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA). Oxford Medical Publications 1979. J Froom-Chairman
3. I.C.D.-9-CM - J Froom representing the Society of Teachers of Family Medicine.
4. H.I.C.D.A.-2-J Froom representing the Society of Teachers of Family Medicine.

5. ICHPPC-2 Defined. Oxford University Press. Report of Classification Committee. World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians 1983. Jack Froom - Chairman.
6. NAPCRG-1. A Process Code for Primary Care: Ad-hoc Committee for Process Coding: North American Primary Care Research Group. Richmond Virginia 1981.
7. International Classification of Process in Primary Care-Produced by the International Classification Committee (*Jack Froom, Chairman*) of W.O.N.C.A. Oxford University Press 1986.
8. Froom J: Forward to International Classification of Primary Care (Ed.) Lamberts H, Wood, M. Oxford University Press 1987.

BOOK REVIEWS

1. Froom J, Lawrence Duane A: Review of article entitled Feinstein, AR, "The problems of the problem oriented record," Ann Intern Med 78: 151-162, 1973 for selected references in Family Medicine, Second Edition, 1975.
2. Froom J: An inventory for primary health care practice by Archie S. Golden, 146 pages. Ballinger Publishing Company, Cambridge, Mass., 1976. Review appeared in Annals of Internal Medicine: 87:1:134, July 1977.
3. Froom J: the Physician's Practice - Ed John M. Eisenberg, et al. Wiley and Sons 1980. Annals of Internal Medicine 94:715, 1981.

EDITORIALS

1. Froom J: Classification of health problems for primary care. Medical Record News 45:6-6-11, October 1974.

2. Froom J: International Classification of Health Problems in Primary Care. JAMA 234:1257 1258, 1975.

3. Froom J: ICHPPC-2-An improved classification system for family practice. J Fam Pract 10:791-792, 1980.

4. Froom J: Chronic disease surveillance. J Fam Pract 23:3111-312, 1986.

5. Froom J: ICHPPC-2 An improved classification system for family practice. Journal of Family Practice 10:791-792

6 Froom J: Measuring the process of Ambulatory Medical Care. Family Medicine 1987; 19:170-171

7. Froom J: Radical therapy? Scand J. Primary Health Care 1987; 5:1-3

8 Froom J: Teaching communication skills 1987; 14:299-301

9. Froom J, Froom P: Consequences of the National Cholesterol Education Program. J Fam Pract 1991; 30:533-536.

10. Froom J: Blood cholesterol lowering in elderly patients. J Amer Boar Fam Pract. 1991; 4:61-62.

11. Froom J: The long pull. Fam Med 1991;23:17.

12. Froom J: The real enemies: Obesity, inactivity and smoking. J Amer Board of Fam Pract. 1991;4:269-271.

INVITED LECTURES AND PAPERS READ AT MEETINGS—recent

1. "Medical Records and Quality of Care Assessment" to New Jersey Medical Directors or the Group Health Plan of New Jersey, Inc., March 17, 1978.

2. "The Future Family Physician: New Tasks and New Tools" presented at Wright State Medical School, Wright-Patterson Air Force Base, Ohio. March 31, 1978.

3. "Health Related Problems of the Single-Parent Family" North American Primary Care Research Group, Toronto, Canada, April 1978.

4. "Patient Expectations and the Family Physician: A comparison of patient expectations in two populations: Rochester, New York, and Ommoord, THE NETHERLANDS — North American Primary Care Research Group, Toronto, Canada, April 1978.

5. "A Classification of Family and Family Diagnoses for Family Physicians" North American Primary Care Research Group, Toronto, Canada, April 1978.

6. Classification of diseases and recording techniques — Community Health Plan of Suffolk, Inc. December 1978.

7. The Family in Family Medicine Research — Keynote address — Michigan State University - Research Day — February 1978.

8. Selective Screening and Surveillance for Lead Poisoning — Educational Implications — American Assoc. of Medical Colleges — New Orleans — October 1978.

9. The Problem-Oriented Medical Record - Southern Medical Association — Atlanta, Georgia - November 1978.

10. Classification of Diseases — Southern Medical Association — Atlanta, Georgia — November 1978.

11. The Spectrum of Otitis Media in Family Practice — World Organization of National Colleges Academies and Academic Associations of General Practitioners — Family Physicians — Montro, Switzerland — May 1978.

12. Scientific Investigation in Family Medicine — Nassau County Medical Center — October 1978.

13. Introduction to the Family: Family Life Cycle — Southside Hospital — Denver, Colorado - April, 1979.

14. Critique of Research Design — Society of Teachers of Family Medicine –- Denver, Colorado -April 1979.
15. Classification of Family — Department of Family Medicine — University of Colorado — Denver, Colorado — May 1979.
16. Organizing Practice Generated Data for Research and Teaching — Case Western Reserve —Cleveland — December 1979.
17. Medical Records for Correctional Facilities — New York State Correctional Department, Health Services Division — February 1980.
18. Urinary Tract Infections — Department of Family Medicine — University of Colorado — December 1981.
19. Classification Systems in Primary Care — Dept. of Family Medicine — University of Colorado — December 1981.
20. New Directions in Primary Care Classification Systems — Panel Discussion — North American Primary Care Research Group — Columbus Ohio — May 1982.
21. Urinary Tract Infections in Primary Care — Post Graduate Family Medicine Course — Stony Brook, NY — March 1982.
22. Low Back Pain — Afula Hospital — Afula, Israel — November 1982.
23. Family Medicine — A Unique Discipline — Medical Staff Conference — Carmel Hospital — Haifa, Israel — November 1982.
24. Diabetes Mellitus — Afula Hospital — Afula, Israel — December 1982.
25. Screening - Department of Family Medicine — Hadassah Hospital — Jerusalem — March 1983.

26. Primary Care Classifications — Department of Social Medicine — Hebrew University — Jerusalem — March 1983.
27. Primary Care Research — Department of Primary Care — Ben Gurion University of the Negev — Beer Sheva, Israel — March 1983.
28. Screening for disease in a family medicine patient population — International Forum on Family Medicine for the Americas, Spain and Portugal. Panama — August 15, 1984.
29. The Problem-Oriented Medical Record, ICHPPC and Practice Based Data Systems — International Forum on Family Medicine for the Americas, Spain and Portugal. Panama — August 16, 1984.
30. Classification of Diseases — Northwestern General Hospital — Burnie — Tasmania — Australia - February 1985.
31. Otitis Media in General Practice — Launceston — Tasmania — Australia — February 1985.
32. Recent Trends in Diabetes Mericy General Hospital — Latrobe — Tasmania — Australia — February 1985.
33. New Developments in the Treatment of Type 2 Diabetes — Royal Hobart Hospital — Tasmania — Australia — February 1985.
34. Diabetes in Primary Care Patients — Department of Family Medicine — University of Sidney — Australia — March 1985.
35. Otitis Media — College of General Practice — Christ Church — New Zealand. Classification of Disease — University of Auckland — New Zealand — March 1985.
36. Otitis Media — Afula Hospital — Israel — July 1985.
37. Low Back Pain — Hadassah Hospital — Israel — October 1985.

38. International Conference on Otitis Media — Jerusalem — Participated in a panel discussion on the natural history and diagnostic criteria

39. Urinary Tract Infection — Hadassah Hospital — Israel — November 1985.

40. Diabetes Mellitus — Carmel Hospital — Israel — November 1985.

41. Otitis Media — Hadassah Hospital — Israel — November 1985.

42. Risks of Referral — Hadassah Hospital — Israel — December 1985.

43. Primary Care Classifications — Hadassah Hospital — Israel — December 1985.

44. Informatics Meeting on Primary Care — Munich — Germany — Computer Compatible Primary Care Classifications Systems — December 1985.

45. Diabetes Mellitus — Tel Aviv University — Israel — January 1986.

46. Selection Bias — Hatzor Clinic — Israel — January 1986.

47. Treating Asymptomatic Patients — Keynote Address — Annual Research Day — Afula, Israel 1990

48. The Cholesterol Controversy, Hebrew University, Jerusalem, Israel 1990

49. Does Chapter XXI Meet the Needs for Healthcare Information in the 1990's? CPHA Symposium, Chicago 1990.

50. Urinary Tract Infections: A proposal for primary care research. Portuguese Hospital: Rio Di Janiero, Brazil.

51. Research in Family Medicine. Practitioner Involvement in Research Networks. Keynote Address. Connecticut Academy of Family Physicians 1991 Scientific Symposium.

52. NIMH International Research Conference on the Classification, Recognition and Treatment of Mental Disorders in General Medical Settings. Winter-Season Morbidity in a Random Sample of Primary Medical Care Outpatients. Washington D.C. - September 23, 1991.

53. Effect of Patient Characteristics, Disease Severity, and Treatment on the Outcome of Acute Otitis Media. A report from IPCN. North American Primary Care Research Group. Quebec, Canada - May 1991.

54. Heart Disease Prevention Research. Wisconsin Research Network. November 1991.

55. Primary Care Practice-Based Research Network. A National and International Perspective. Keynote address. Wisconsin Research Network - November 1991.

56. Cholesterol Reduction and Other Cardiovascular Disease Prevention Interventions. Grand Rounds, Duke University. Department of Family Medicine - November 1991.

57. Medical School Education. Contrasts Between Japan and the United States. Okayama Medical School. Japan - September 1991.

58. Urinary Tract Infections in Primary care Patients. Hadassah Medical School Jerusalem - February 12, 1992.

59. Detection of Depression in Primary Care Patients. National Association of Family Physicians Annual research Convocation. Tiberias. March 3, 1992.

60. Research Design. Ben-Gurion University of the Negev. March 10, 1992.

61. Detection of Occult Hypothyroidism in Primary Care Populations. Ben-Gurion University of the Negev. March 11, 1992.

62. Acute Otitis media: Findings from a Nine-country Study. Hadassah Medical School. March 23 1992.

63. June 8, 1992: Controversies in the Medical Literature: Keynote address at a conference on teaching technique for family physicians. Tel Aviv, University Israel.

AUDIO

Froom J: Office screening for lead poisoning in children. Highlights from the American Academy of Pediatrics 1977 Annual Meeting, New York City, November 5-10, 1977. AUDIO DIGEST Foundation. Pediatrics 24:1, Side B, January 17, 1978.

SCIENTIFIC EXHIBITS - NATIONAL MEETINGS

1. "The Diagnostic Index--E Book" with Drs. Eugene Farley, Donald F. Treat, and Samuel Henck to the Annual Scientific Assembly of the American Academy of Family Physicians, October 14-17, 1974, Los Angeles, California. First Prize awarded for outstanding exhibit.
2. Lead Screening by Primary Care Physician, American Academy of Pediatrics, New York 1977
   American Public Health Associates, Washington 1977

HOSPITAL MEDICAL STAFF MEMBERSHIP

University Hospital, State University of New York at Stony Brook, N.Y. 1978-Present

AWARDS AND HONORS

1. Scholar in Residence at the Rockefeller Bellagio Study and Conference Center April 1982.
2. Fulbright - Hays Fellowship to teaching Israel October 1982-March 1983.
   Visiting Professor - Technion University Haifa. October 1982-March 1983.

Visiting Professor - University of Tel Aviv. October 1982-March 1983.

3. Visiting Professor - Hebrew University - Jerusalem - May 1985 - January 1986 and Jan-July 1992.
4. Hames Research Award - Society of Teachers of Family Medicine 1987.
5. Certificate of Excellence - Society of Teachers of Family Medicine 1990.
6. Visiting Professor - Okayama Medical School - Japan - September 1991.
7. Life Honorary member in the Israel Association of Family Physicians, June 1992.
8. Fellow of WONCA (World Organization of Family Physicians.)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF MINNA BARRETT

Minna Barrett declares:

1. I am competent to testify and do so of my own personal knowledge. I submit this declaration in support of plaintiffs' motion to add Governor Mario M. Cuomo as defendant herein.

2. On Sunday, September 18, 1994, I watched a televised panel discussion with Governor Mario M. Cuomo and I recall the following discussion.

3. Governor Cuomo had been discussing the high prison population and violence in the streets. He was asked about his position on the death penalty. He said he was opposed.

In the context of a fuller discussion about issues of the gubernatorial race, a panelist asked the Governor how he felt about the pending lawsuit challenging the Attorney General on hastening death and allowing mentally competent terminally ill people control over their own deaths. Governor Cuomo responded that he was opposed to that right.

4. The panelist further pressed the issue, asking the Governor how he could oppose the right of mentally competent individuals, faced with terminal and horribly painful diseases, to alleviate this suffering by hastening a sure death and how he could possibly equate the death penalty, an act of punishment, with assisted death, an act of mercy.

5. Governor Cuomo responded that the panel had just finished discussing the violence that permeates society, whether it take the form of the violence that children face on the streets or the form of the death penalty. Governor Cuomo explained that allowing terminally ill individuals the right to hasten their own deaths is the equivalent of the State condoning the above mentioned kinds of violence.

6. The panelist then asked again how he could equate murder and violence with mercy and suggested that physician-

assisted death in the case of mentally competent, terminally ill individuals should be viewed as a right. She asked him what his position on abortion was, to which Cuomo firmly replied that abortion was a woman's right which was not up to review.

7. When the panelist again stated that she did not understand how he could equate physician-assisted death with murder, Cuomo told her that she had "no conscience." He then drew his own analogy, declaring that permitting these terminally ill individuals to hasten their own deaths was no different than condoning the murder we see in the streets by "putting guns in the hands of children."

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
Oceanside, New York

/s/ MINNA S. BARRETT
Minna Barrett

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
October 14, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

AMENDED COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

2. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

3. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

4. Timothy E. Quill, M.D., is a physician licensed in the State of New York who practices internal medicine in Rochester, New York. Dr. Quill sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

5. G. Oliver Koppell, the Attorney General of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

6. Mario M. Cuomo, the Governor of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

JURISDICTION AND VENUE

7. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343(a)(3).

8. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

9. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

10. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

11. There are mentally competent, terminally ill adults in the State of New York who desire to have the choice to seek physician assistance to hasten their deaths.

12. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

13. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

14. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Dr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

15. Plaintiffs repeat and reallege paragraphs 1 through 14 of their Complaint.

16. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

17. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

18. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

19. Plaintiffs repeat and reallege paragraphs 1 through 14 of their Complaint.

20. The Fourteenth Amendment guarantees patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

21. Patient-Plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law are invalid

under the Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendants, and all who act in concert with them, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
October 12, 1994

PERKINS COIE
Kathryn L. Tucker
1201 Third Avenue, 40th Floor
Seattle, Washington 98101
(206) 583-8888

HUGHES HUBBARD & REED

By: CARLA A. KERR
Carla A. Kerr (CK-5194)

One Battery Park Plaza
New York, New York
(212) 837-6000

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed November 4, 1994

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,

Defendant.

Upon plaintiffs' motion to amend their complaint so as to add Mario Cuomo, the Governor of the State of New York, as a party defendant in this matter,

IT IS HEREBY ORDERED, that leave to so amend is granted. Plaintiffs may file and serve such an amended complaint in this matter.

Dated: New York, New York
October 17, 1994

/s/ THOMAS P. GRIESA
THOMAS P. GRIESA
Chief Judge, U.S.D.C.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Filed October 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

Order to Show Cause

Upon all the pleadings and proceedings herein and upon the oral motion of plaintiffs in open court on October 19, 1994, it is hereby

ORDERED that plaintiffs may amend their complaint so as to add Robert M. Morgenthau, District Attorney of New York County, as a party defendant in this matter;

IT IS FURTHER ORDERED, that plaintiffs shall serve upon the District Attorney a Summons and Second Amended Complaint, as well as all material filed in this action to date, by hand delivery on October 20, 1994;

IT IS FURTHER ORDERED, that defendant Cuomo as Governor and defendant Morgenthau as District Attorney show cause by serving, by hand, any supplemental papers in opposition on or before November 1, 1994, at 5 o'clock p.m., why a preliminary injunction should not issue pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining the defendants, their officers, agents, servants, employees, attorneys, successors in office and all others acting under their authority, control, direction, permission or license, and all persons acting in concert and participation with them from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths;

IT IS FURTHER ORDERED, that service of this order to show cause upon defendants on October 20, 1994, by facsimile or by hand, shall be deemed sufficient service as to defendants.

Dated: New York, New York
October 20, 1994

/s/ THOMAS P. GRIESA
Chief Judge Thomas P. Griesa
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Received October 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SECOND AMENDED COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

2. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

3. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

4. Timothy E. Quill, M.D., is a physician licensed in the State of New York who practices internal medicine in Rochester, New York. Dr. Quill sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

5. G. Oliver Koppell, the Attorney General of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

6. Mario M. Cuomo, the Governor of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

7. Robert M. Morganthau, District Attorney of New York County, has the powers entrusted to him under the Constitu-

tion and County Law of the State of New York. He is sued in his official capacity.

JURISDICTION AND VENUE

8. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. 1331 and 1343(a)(3).

9. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

10. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

11. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

12. There are mentally competent, terminally ill adults in the State of New York who desire to have the choice to seek physician assistance to hasten their deaths.

13. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

14. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are ter-

minally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

15. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Dr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

16. Plaintiffs repeat and reallege paragraphs 1 through 15 of their Complaint.

17. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

18. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

19. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

20. Plaintiffs repeat and reallege paragraphs 1 through 15 of their Complaint.

21. The Fourteenth Amendment guarantees patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

22. Patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of Sections 125.15(3) and 120.30 of the New York Penal invalid under the

Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendants, and all who act in concert with them, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
October 20, 1994

PERKINS COIE
Kathryn L. Tucker
1201 Third Avenue, 40th Floor
Seattle, Washington 98101
(206) 583-8888

HUGHES HUBBARD & REED

By: CARLA A. KERR
Carla A. Kerr (CK-5194)

One Battery Park Plaza
New York, New York
(212) 837-6000

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, *et al.*,

Defendants.

DEFENDANTS G. OLIVER KOPPELL AND MARIO M. CUOMO'S ANSWER AND AFFIRMATIVE DEFENSES TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendants G. Oliver Koppell and Mario M. Cuomo, by and through counsel, answer plaintiffs' second amended complaint ("complaint"), as follows:

1. Deny knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 1, 2, 3 and 4 of the complaint.

2. Admit the allegations set forth in paragraphs 5, 6, and 7 of the complaint, except that plaintiffs' assertion that defendants are sued in their official capacities states a legal conclusion to which no responsive pleading is required.

3. Paragraph 8 of the complaint states legal conclusions to which no responsive pleading is required. The Court is respectfully referred to the statutes cited therein for their contents.

4. Deny the allegations set forth in paragraph 10 of the complaint, except assert that the first two sentences state legal conclusions to which no responsive pleading is required, and respectfully refer the Court to the statutes cited therein for their contents.

5. Deny knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14 and 15 of the complaint.

6. In response to paragraph 16 of the complaint, repeat and reallege their answers to paragraphs 1 through 15 of the complaint and incorporate them by reference.

7. Deny the allegations set forth in paragraphs 17, 18 and 19 of the complaint.

8. In response to paragraph 20 of the complaint, repeat and reallege their answers to paragraphs 1 through 19 of the complaint and incorporate them by reference.

9. Deny the allegations set forth in paragraphs 21 and 22 of the complaint.

FIRST AFFIRMATIVE DEFENSE

10. The complaint fails in whole or in part to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

11. This action is barred in whole or in part by the Eleventh Amendment to the United States Constitution.

12. The Court lacks jurisdiction over the subject matter.

THIRD AFFIRMATIVE DEFENSE

13. This action does not present a case or controversy under Article III of the United States Constitution.

FOURTH AFFIRMATIVE DEFENSE

14. The issue presented is a non-justiciable political question.

WHEREFORE, defendants Koppell and Cuomo respectfully demand that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
October 28, 1994

G. OLIVER KOPPELL
Attorney General of the
State of New York

By: MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)
SUSAN L. WATSON (SW 0023)
Assistant Attorneys General
120 Broadway—24th Floor
New York, NY 10271
212-416-8570

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.;
SAMUEL C. KLAGSBRUN, M.D.;
HOWARD A. GROSSMAN, M.D.; and
GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL,
Attorney General of the State of New York;
MARIO M. CUOMO,
Governor of the State of New York; and
ROBERT M. MORGENTHAU,
District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION

ROBERT M. MORGENTHAU
District Attorney
New York County
Defendant Pro Se
One Hogan Place
New York, New York 10013
(212) 335-9000

MARK DWYER
JAMES M. McGUIRE
ASSISTANT DISTRICT ATTORNEYS
Of Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION

INTRODUCTION

Defendant Robert M. Morgenthau, the District Attorney of New York County, respectfully submits this memorandum of law in opposition to plaintiffs' motion for a preliminary injunction enjoining defendant Morgenthau, the other defendants and all persons acting in concert with the named defendants, "from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths" (Oct. 20, 1994 Order to Show Cause at 2). As argued below in Point I, plaintiffs' motion should be denied because they have failed to demonstrate that issuance of the preliminary injunction is necessary to prevent irreparable injury to their alleged constitutional rights.* Moreover, as argued below in Point II, plaintiffs' motion should also be denied because the injunction they seek is impermissibly vague under Fed. R. Civ. Pro. 65(d) and is otherwise overly broad.

At the outset, however, it is by no means apparent why plaintiffs amended their complaint to add District Attorney Morgenthau, as opposed to any of the other District Attorneys in New York City or State, as a party defendant. After all, defendant Morgenthau can prosecute only those crimes which have a sufficient nexus to New York County. *See* N.Y. Crim. Pro. Law § 20.40 (McKinney's 1992). And plaintiffs do not allege any facts tending to show that the physician-plaintiffs are in any jeopardy of being prosecuted in New York County. In any event, defendant Morgenthau will address this matter in his answer or by appropriate motion.

---

* Defendant Morgenthau also submits that the federal constitution does not confer upon plaintiffs the suicide-related rights upon which they rely and that, accordingly, plaintiffs have failed to show a likelihood of success on the merits. However, defendant Morgenthau will not address the merits in this memorandum. Instead, defendant Morgenthau adopts the arguments on the merits made by defendant Koppell and *Amicus Curiae* New York State Catholic Conference.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, *et al.*,

Defendants.

AFFIDAVIT OF MICHAEL S. POPKIN ON BEHALF OF DEFENDANT MARIO M. CUOMO IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

STATE OF NEW YORK):
: SS.
COUNTY OF NEW YORK):

MICHAEL S. POPKIN, being duly sworn, deposes and says, as follows:

1. I am an Assistant Attorney General employed in the office of G. OLIVER KOPPELL, Attorney General of the State of New York, and I make this affidavit on behalf of Mario M. Cuomo, Governor of New York, in response to the

Court's Order to Show Cause in this matter, dated October 20, 1994. I have been duly authorized to make this affidavit. I make it upon personal knowledge, as well as information and belief, the source of such knowledge, information and belief being my familiarity with the proceedings herein; and conversations with the staff of the Governor's office.

2. By this affidavit, the Governor joins in the Attorney General's opposition to plaintiffs' Motion for a Preliminary Injunction, and in the Attorney General's pending Cross-Motion for Judgment on the Pleadings in this matter. For the reasons which appear below, the Governor will not—except for this affidavit,—submit additional papers on the motions under submission.

3. The Governor is sued in this case "in his official capacity." Plaintiffs' Second Amended Complaint at ¶6. With respect to this, it is the position of the Governor that he is not a necessary party to this suit. The Governor personally has not actually taken or threatened any action in this matter for which he is joined as a defendant. It is therefore inappropriate that he be so joined. As is the case with the Attorney General, the Governor does not possess primary authority to enforce the criminal statutes which are at issue in this case. Rather it is the District Attorneys of the several counties of the State who primarily enforce these laws. Parallelling the argument already before the Court, "[N]othing in the Penal Law, the Executive Law, or any other New York Statute authorizes the [Governor] to supervise or dictate to the District Attorneys of the various counties of the State of New York." Defendant's Memorandum of Law In Opposition to Motion for a Preliminary Injunction and in Support of Cross-Motion for Judgment on the Pleadings, at 3-4. Therefore, with respect to the Governor, this case continues not to present a case or controversy ripe for adjudication under Article III of the United States Constitution. The Governor is no more likely to prosecute the plaintiff-physicians in this case than is the Attorney General.

4. With respect to the enforcement of the criminal laws at issue in this case, the Governor believes that New York's various District Attorneys will continue to exercise vigilence and discretion. There is nothing to suggest that these officials will fail to exercise their responsibilities. The Governor's presence in this suit therefore adds nothing from the law enforcement point of view.

5. Further, where the constitutionality of the challenged statutes is concerned, the Governor believes that the interests of the State have been well represented in the papers already submitted by the Attorney General pursuant to his obligation to defend the constitutionality of state statutes. Therefore, because the Attorney General can adequately represent the State's interest in upholding the validity of its laws, the Governor is similarly not a necessary party to this action. Except as to his presence in this case as a defendant, additional arguments on his part are unnecessary.

6. For these reasons, as already indicated, the Governor will not (besides this affidavit) submit additional papers on the cross-motions under submission. In general, the Governor joins in the Attorney General's motion that the case be dimissed on the pleadings for failure to State a cause of action, and in the Attorney General's opposition to plaintiffs' request for a preliminary injunction. And in particular, as it pertains to himself, the Governor asks that the case be dismissed for failure to meet the requirements of Article III of the United States Constitution.

/s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN
Assistant Attorney General

Sworn to before me this
day of 1st day of November, 1994

/s/ [ILLEGIBLE]
Assistant Attorney General of the
State of New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

94 Civ. 5321 (TPG)

ROBERT M. MORGENTHAU
District Attorney
New York County
One Hogan Place
New York, New York 10013
(212) 335-9000

JAMES M. MCGUIRE
Assistant District Attorneys
Of Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendant Robert M. Morgenthau answers plaintiffs' second amended complaint as follows:

1. Denies knowledge or information sufficient to form belief as to the truth of the allegations set forth in paragraphs 1, 2, 3, and 4 of the complaint.

2. Admits the allegations set forth in paragraphs 5, 6, and 7 of the complaint, except that plaintiffs' assertions that defendants are sued in their official capacities states a legal conclusion to which no responsive pleading is required.

3. Paragraphs 8 and 9 of the complaint state legal conclusions to which no responsive pleading is required.

4. Denies the allegations set forth in paragraph 10 of the complaint, except asserts that paragraph 10 states legal conclusions to which no responsive pleading is required, and respectfully refers the Court to the statutes cited therein for their contents.

5. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14 and 15 of the complaint.

6. In response to paragraph 16 of the complaint, repeats and realleges his answers to paragraphs 1 through 15 of the complaint and incorporates them by reference.

7. Denies the allegations set forth in paragraphs 17, 18 and 19 of the complaint.

8. In response to paragraph 20 of the complaint, repeats and realleges his answers to paragraphs 1 through 19 of the complaint.

9. Denies the allegations set forth in paragraphs 21 and 22 of the complaint.

DEFENSES

10. The complaint fails to state a claim upon which relief can be granted.

11. The action does not present a case or controversy under Article III of the United States Constitution.

WHEREFORE, defendant Robert M. Morgenthau respectfully demands that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
November 9, 1994

ROBERT M. MORGENTHAU
District Attorney
New York County

By: JAMES M. McGUIRE
JAMES M. McGUIRE (JM 5539)
Assistant District Attorney
One Hogan Place
New York, New York 10013
(212) 335-9322

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
Rochester, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION OF SAMUEL C. KLAGSBRUN, M.D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION
OF HOWARD A. GROSSMAN, M.D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants.

OPINION

APPEARANCES

PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, WA 98101

Of Counsel:

Kathryn L. Tucker, Esq.
David J. Burman, Esq.
Thomas L. Boeder, Esq.

HUGHES HUBBARD & REED
One Battery Park Plaza
New York, NY 10004

Of Counsel:

Carla A. Kerr, Esq.
Tracy E. Poole, Esq.

Attorneys for Plaintiffs

G. OLIVER KOPPELL
Attorney General of the State of New York
120 Broadway - 24th Floor
New York, NY 10271

Of Counsel:

Michael S. Popkin, Esq.
Assistant Attorney General

ROBERT M. MORGENTHAU
District Attorney
New York County
One Hogan Place
New York, NY 10013

Of Counsel:

Mark Dwyer, Esq.
James M. McGuire, Esq.
Assistant District Attorneys

Attorneys for Defendants

NEW YORK STATE CATHOLIC CONFERENCE
33 Elk Street
Albany, NY 12207

Of Counsel:

Michael L. Costello, Esq.
Richard E. Barnes, Esq.
Clarke D. Forsythe, Esq.
Paul Benjamin Linton, Esq.

Amicus Curiae

LEGAL CENTER FOR THE DEFENSE OF LIFE
210 East 23rd Street
Suite 5F
New York, NY 10010

Of Counsel:

Michael P. Tierney, Esq.
John M. McSherry, Esq.
Walter T. Clark, Esq.

Amicus Curiae

GRIESA, *Chief Judge*

New York law makes it a crime to aid a person in committing suicide, or in attempting to commit suicide. Plaintiffs urge that these provisions violate the United States Constitution, to the extent that they apply to situations where a physician aids the commission of suicide by a mentally competent, terminally ill adult wishing to avoid continued severe suffering, by prescribing a death-producing drug which the patient takes. Plaintiffs claim that a person has a constitutional right to terminate his life under these circumstances, and that a physician has a corresponding constitutional right not to be prosecuted for aiding a patient in the exercise of the patient's right.

Plaintiffs move for a preliminary injunction against the enforcement of the relevant statutes, §§ 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give the kind of assistance described above. Defendants oppose plaintiffs' motion and cross-move for judgment on the pleadings dismissing the action.

Plaintiffs' motion for preliminary injunction is denied. Defendants' cross-motion to dismiss the action is granted. The motion to dismiss will be treated as one for summary judgment since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction. There is no dispute on the essential facts and the issues presented are ones of law.

The Parties

The action was commenced on July 20, 1994. The original complaint named three physician plaintiffs, Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman. There were also three patient plaintiffs who asserted that they were terminally ill and wished to have the assistance of physicians in committing suicide. All three of the patient plaintiffs have now died, leaving only the three physician plaintiffs.

The original complaint named only the Attorney General of the State of New York as a defendant. However, it was argued that the Attorney General was not the proper defendant because he was not responsible for prosecutions under the criminal laws of the State. The complaint has now been amended to add as defendants Governor Mario M. Cuomo and New York County District Attorney Robert M. Morgenthau. There is no longer any question about the fact that there are sufficient defendants present to allow the issues in the case to be litigated.

Amicus curiae briefs in opposition to plaintiffs' position have been filed by the New York State Catholic Conference and the Legal Center for the Defense of Life.

The Relevant Record

The Original Complaint

The original complaint of July 20, 1994 contained, among other things, allegations that the three patient plaintiffs were mentally competent adults; that they were in the terminal stages of fatal illnesses; that they faced progressive loss of bodily function and integrity as well as increasing suffering; and that they desired medical assistance in the form of medications prescribed by physicians to be self-administered for the purpose of hastening death.

As to the three physician plaintiffs, the complaint alleged that, in the regular course of their medical practice, they

treated terminally ill patients who requested assistance in the voluntary self-termination of life; that under certain circumstances it would be consistent with the standards of these physicians to prescribe medications to such patients which would cause death, since without such medical assistance these patients could not hasten their deaths in a certain and humane manner.

The original complaint alleged that the patient plaintiffs have a constitutional right under these circumstances to terminate their lives with this type of medical assistance; and that since the New York Penal Law makes it a crime to render such assistance, these provisions violate the constitutional rights of both the patient plaintiffs and the physician plaintiffs, specifically rights under the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

Amendments to the Complaint

An amended complaint was filed on October 14, 1994. By this time, two of the three patient plaintiffs had died. The allegations about the remaining patient plaintiff were carried over into the amended complaint, as were the claims of the physician plaintiffs.

The second amended complaint was filed October 20, 1994. It was essentially the same as the previous complaint except for naming New York County District Attorney Robert M. Morgenthau as a defendant.

Subsequently, the third patient plaintiff died, thus leaving the three physicians as the only plaintiffs.

An answer was filed in August 1994 to the original complaint denying that plaintiffs have any valid claim. No amended answers were filed responding to the amended complaints, but the court deems the original answer to be a sufficient denial of plaintiffs' claims.

Declarations Filed on Motion For Preliminary Injunction

The motion for preliminary injunction was filed on September 16, 1994. In support of the motion, each of the three patient plaintiffs submitted declarations which confirmed the allegations in the complaint and added details about their diseased conditions and suffering.

The three physician plaintiffs have submitted declarations affirming their belief that proper and humane medical practice should include the ability to prescribe medication which will enable a patient to commit suicide under the circumstances described in this case.

A declaration by Quill also describes the following incident. In 1990 he treated a terminally ill patient, who feared a lingering death and who apprised Quill that she would act on her own to hasten death if he refused to assist her to do so. Quill made barbiturates available to the patient, which she could use to induce sleep, but which she could also take to end her life by an overdose at the point she desired to do so. She agreed to meet with Quill prior to taking any overdose. The patient reached the point where she desired to end her life. She met with Quill "to insure that all alternatives had been explored," after which she took the overdose and died. Quill was not present at the time of death. Subsequently, Quill wrote an article in the New England Journal of Medicine describing these events. This led to what Quill describes as a "very public criminal investigation" in New York State, and presentation to a grand jury. Quill testified before the grand jury, as did other witnesses. The grand jury did not indict.

The other two physician plaintiffs, Klagsbrun and Grossman, describe in their declarations specific incidents when terminally ill patients wished assistance in hastening death. Each doctor asserts that he refrained from rendering such assistance because of possible prosecution under the New York statutes.

The Statutes

Section 125.15(3) of the New York Penal Law provides in relevant part:

> A person is guilty of manslaughter in the second degree when:
>
> . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

Section 120.30 provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

Violation of either statute is a felony.

Plaintiffs are not seeking to strike down these statutes in their entirety. Plaintiffs claim that the statutes are unconstitutional only insofar as they apply to the type of physician assisted suicide at issue in this case. Both plaintiffs and defendants agree that, if a physician renders the type of assistance described here, he will violate § 125.15(3) where actual death by suicide occurs, and § 120.30 where the patient attempts to commit suicide and fails.

DISCUSSION

Justiciability

Defendants assert that there is no justiciable case or controversy as required by Article III of the Constitution. According to defendants, plaintiffs show nothing more than a speculative possibility of prosecution, rather than any actual threat of prosecution.

The court does not agree with these assertions. The relevant law is well set forth in *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979). There the Supreme Court dealt

with a constitutional challenge to certain Arizona agricultural labor regulations. The case was brought by a union and parties connected with the union. The Court held that certain of the plaintiffs' claims were justiciable and certain were not. The Court stated that when contesting the constitutionality of a criminal statute it is not necessary that the plaintiff first expose himself to actual prosecution. When the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution, a sufficient controversy is presented. On the other hand, where there are no fears of prosecution except those which are imaginary or speculative, there is no basis for federal court action. "Abstract questions" are not justicible. *Id.* at 297-99.

In *Babbitt* the Court upheld federal jurisdiction over claims where (1) the plaintiffs asserted both the intention and the constitutional right to engage in conduct which would violate the regulations, and (2) the state had not disavowed the intention of imposing criminal penalties. Thus the plaintiffs were "not without some reason in fearing prosecution," and the positions of the parties were "sufficiently adverse" to present a proper case. *Id.* at 302-3.

As to the claims in *Babbitt* held not to be justiciable, the Court found that it was uncertain whether the particular activities involved would actually give rise to a problem under the regulations. The factual pattern which might develop was unclear. *Id.* at 303-4.

Another instructive case is *Doe v. Bolton*, 410 U.S. 179 (1973). This was a companion abortion case to *Roe v. Wade*, 410 U.S. 113 (1973). In *Doe*, the plaintiffs challenged the Georgia anti-abortion statute. The Court held, among other things, that the claim of the physician plaintiffs presented a justiciable controversy. This was true despite the fact that none of them had been prosecuted or threatened with prosecution. The Court pointed out, 410 U.S. at 188:

> The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief.

On the basis of these authorities, the court holds that the instant case presents a justiciable controversy under Article III of the Constitution. The three physician plaintiffs seek to carry on activities which they contend are within their constitutional rights and which would violate the New York Penal Law. This is not a case about some activity in which a plaintiff might possibly engage and which might create a hypothetical issue of criminal liability. The physician plaintiffs credibly assert that they have had cases and continue to have cases in which their services are urgently sought to assist in the commission of suicide in the way described in this case. As to whether there is a threat of prosecution for so assisting, there has been the grand jury proceeding about plaintiff Quill. Although no indictment was returned, the State has by no means disavowed the intention of acting against physicians in future cases. Indeed, the State has in the present action vigorously defended its right to apply the statutes to such conduct. Thus, there is a credible threat of prosecution giving rise to sufficiently adverse positions so that a justiciable controversy exists. What is presented here is no mere abstract question.

This is particularly true since the issue of physician assisted suicide is being pressed by segments of the medical community and has sparked sharp public debate. It is most unlikely that the conduct at issue in this case would be ignored by the law enforcement authorities.

It is appropriate to note that the primary right claimed is that of the patient—*i.e.*, the right to decide to terminate one's life and to do so by suicide. However, if such a constitutional right resides in the patient, then there would be a corresponding constitutional right of the physician not to be prosecuted for assisting in the exercise of the patient's con-

stitutional right. The physician plaintiffs in the present case have standing to raise the whole range of issues—both as to the patient's asserted right to terminate his life and the physician's right to be free from prosecution for rendering assistance. *See Doe*, 410 U.S. at 188.

The Due Process Issue

The Fourteenth Amendment provides that no state may "deprive any person of life, liberty, or property, without due process of law." It is now established that there are certain subjects which are so fundamental to personal liberty that governmental invasion is either entirely prohibited or sharply limited. One recent articulation of this concept by the Supreme Court, which is strongly relied upon by plaintiffs, is contained in the plurality opinion in *Planned Parenthood v. Casey*, 112 S.Ct. 2791, 2807 (1992).

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family-relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Casey confirmed the holding in *Roe v. Wade* that the Fourteenth Amendment protects a woman's decision to abort a pregnancy in the pre-viability stage.

Plaintiffs also rely on the Supreme Court decision in *Cruzan v. Director Missouri Dep't of Health*, 497 U.S. 261 (1990). In that case a woman suffered an accident, after which she could only be kept alive by artificial feeding and hydration. She lost her cognitive faculties, and apparently had no possibility of recovery. Her parents desired to have the life-sustaining apparatus withdrawn. The Supreme Court of Missouri held that it was necessary, before such a step could be taken, to show by clear and convincing evidence that the injured woman would have desired withdrawal of the medical devices, and further held that such evidence was lacking.

Although the United States Supreme Court, in reviewing the case, did not provide a single convenient statement of the question before it, a fair summary of the issues would appear to be whether the injured woman had a constitutional right requiring the hospital to withdraw life-sustaining treatment; whether this right could be exercised on behalf of the woman by her parents; and whether the exercise of this right was unduly hampered by the evidence rule imposed by the state court. In approaching these questions the Supreme Court stated:

> The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

Id. at 278. The Court went on to discuss the specific issue of whether this general right to refuse treatment would apply where such refusal might lead to death.

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent

person a constitutionally protected right to refuse life-saving hydration and nutrition.

Id. at 279. Thus, the Court stopped short of actually deciding that there is a constitutional right to terminate medical treatment necessary to sustain life, although the Court *assumed* the existence of such a right for the purpose of going on to the other issues in the case. As to these, the Court held that the state had the power to require evidence of the patient's wishes rather than allowing the decision solely at the behest of family members, and that the state could properly require proof of the patient's wishes by clear and convincing evidence.

Plaintiffs in the present case argue that the reasoning and holdings of the Supreme Court in *Roe* and *Casey* are broad enough to establish that there is a fundamental right on the part of a terminally ill patient to decide to end his life, and to do so with the type of assistance described in this case. Plaintiffs also interpret the *Cruzan* decision as being tantamount to a holding that a terminally ill person has a constitutional right to require the withdrawal of life-sustaining treatment. Plaintiffs argue that it follows inevitably that there is a constitutional right of physician assisted suicide under the circumstances and in the manner at issue here.

Plaintiffs' reading of these cases is too broad. The Supreme Court has been careful to explain that the abortion cases, and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of other fundamental rights on different subjects. *See, e.g., Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68, n.15 (1973). With regard to *Cruzan*, as already described, the Court did not actually make the holding upon which plaintiffs seek to rely. In any event, it would appear clear that suicide has a sufficiently different legal significance from requesting withdrawal of treatment so that a fundamental right to suicide cannot be implied from *Cruzan*.

The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights

"not readily identifiable in the Constitution's text" are deserving of constitutional protection. *See Bowers*, 478 U.S. at 191. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions. *Id.* at 191-92. *See also Moore v. East Cleveland*, 431 U.S. 494, 503 (1977).

The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right. The history of the treatment of suicide by the law has been dealt with in a number of recent studies. *See, e.g.*, Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1986); Note, *Physician-Assisted Suicide and New York Law*, 57 Alb. L. Rev. 819, 824-32 (1994); The New York State Task Force on Life and The Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 54-56 (1994). Justice Scalia's concurring opinion in *Cruzan*, 497 U.S. at 294-95, also contains a useful historical summary.

Suicide was a crime under English common law, even if the motive was to avoid suffering and illness. Obviously, no punishment could be inflicted upon the deceased, but sanctions were imposed by way of forfeiture of property and ignominious burial. The American colonies apparently adopted this common law rule, but it has been gradually abandoned so that no state in this country now criminalizes suicide or attempted suicide. However, as Justice Scalia states, this change in the law resulted from a desire "to spare the innocent family and not to legitimatize the act." *Cruzan*, 497 U.S. at 294.

As to assisting suicide, the majority of states in this country have long imposed criminal penalties on one who aids another in committing suicide. *See Cruzan*, 497 U.S. at 280 (majority opinion). The Model Penal Code, adopted by the American Law Institute, provides that it is a crime to assist a suicide. *Model Penal Code* § 210.5(2) and comment at 100 (American Law Institute 1980). The comment states:

> Self destruction is surely not conduct to be encouraged or taken lightly. The fact that penal sanctions wil prove ineffective to deter the suicide itself does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of the suicide victim.

Plaintiffs are, of course, suggesting a limited form of physician assisted suicide. But plaintiffs have pointed to nothing in the historical record to indicate that even this form of assisted suicide has been given any kind of sanction in our legal history which would help establish it as a constitutionalright.

For these reasons, the court holds that the type of physician assisted suicide at issue in this case does not involve a fundamental liberty interest protected by the Due ProcessClause of the Fourteenth Amendment.

The Equal Protection Issue

Plaintiffs contend that even if there is no fundamental right to engage in assisting a patient's suicide under the Due Process Clause, they should prevail under the Equal Protection Clause. Their argument proceeds thus. It is established under New York law that a competent person may refuse medical treatment, even if the withdrawal of such treatment wil result in death. *See, e.g., Rivers v. Katz*, 67 N.Y.2d 485, 493, 504 N.Y.S.2d 74, 78, 495 N.E.2d 337 (1986); *In Re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981); *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

Plaintiffs further argue that such refusal of treatment is essentially the same thing as committing suicide with the advice of a physician. Plaintiffs urge that for the State to sanction one course of conduct and criminalize the other involves discrimination which violates the Equal Protection Clause of the Fourteenth Amendment.

The issue is whether the distinction drawn by New York law has a reasonable and rational basis. *Dandridge v. Williams*, 397 U.S. 471, 485, 487 (1969). To certain ways of thinking, there may appear to be little difference between refusing treatment in the case of a terminally ill person and taking a dose of medication which leads to death. But to another way of thinking there is a very great difference. In any event, it is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide. Clearly in the present public debate there are sincere and conscientious advocates for and against the concept of physician assisted suicide. Under the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State.

For these reasons the court holds that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment.

It should be noted that one federal district court has taken a view contrary to what is expressed in this opinion as to both the due process and the equal protection issues. *Compassion in Dying v. Washington*, 850 F. Supp. 1455 (W.D. Wash. 1994). That ruling is on appeal to the Ninth Circuit.

CONCLUSION

Plaintiffs' motion for a preliminary injunction is denied. Defendants' motion to dismiss, treated as a motion for summary judgment, is granted, and the action is dismissed.

SO ORDERED.

Dated: New York, New York
December 15, 1994

/s/ THOMAS P. GRIESA
Thomas P. Griesa
U.S.D.J.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 CIVIL 5321(TPG)
Filed December 21, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants.

JUDGMENT

Plaintiffs having moved for a preliminary injunction against the enforcement of the relevant statutes, Sections 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give the kind of assistance described the Court's Opinion, defendants having opposed the motion and having cross-moved for judgment on the pleadings dismissing the action, and the said motions having come before the Honorable THOMAS P. GRIESA, U.S.D.J., and the Court on its own initiative having treated defendants' motion to dis-

miss as a motion for summary judgment, and the Court thereafter on December 16, 1994, having rendered its opinion (#74086); denying plaintiffs' motion for a preliminary injunction, and granting defendants' motion to dismiss, treated as a motion for summary judgment, and dismissing the action, it is,

ORDERED, ADJUDGED AND DECREED: That plaintiffs' motion for a preliminary injunction be and it is hereby denied, and it is further,

ORDERED, that defendants' motion to dismiss, treated as a motion for summary judgment, be and it is hereby granted, and it is further,

ORDERED, that the action be and it is hereby dismissed for the reasons stated in the Court's Opinion, dated December 16, 1994.

DATED: NEW YORK, NEW YORK
December 21, 1994

/s/ JAMES M. PARKISON
Clerk

By: RONALD ? CHURCH
Deputy Clerk

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—v.—

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CR 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

NOTICE OF APPEAL

Notice is hereby given that TIMOTHY E. QUILL, SAMUEL C. KLAGSBRUN, and HOWARD A. GROSSMAN, plaintiffs in the above-named case, hereby appeal to the United States Court of Appeals for the Second Circuit from the Judgment entered in this action on December 21, 1994.

DATED: New York, New York
January 3, 1995

PERKINS COIE
Kathryn L. Tucker
1201 Third Avenue, 40th Floor
Seattle, Washington 98101
(206) 583-8888

HUGHES HUBBARD & REED

By: CARLA A. KERR
Carla A. Kerr (CK-5194)

One Battery Park Place
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

TO: ROBERT M. MORGENTHAU
District Attorney
New York County
One Hogan Place
New York, New York 10013
Attn: James M. McGuire, Esq.

DENNIS C. VACCO
Attorney General of the State
of New York
120 Broadway, 24th Floor
New York, New York 10271
Attn: Michael S. Popkin, Esq.

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 60—August Term, 1995

(Argued: September 1, 1995 Decided: April 2, 1996)

Docket No. 95-7028

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs-Appellants,

—v.—

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants-Appellees.

Before:

MINER and CALABRESI, *Circuit Judges*,
and POLLACK, *Senior District Judge*.*

---

* The Honorable Milton Pollack of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from summary judgment for defendants entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) in action to declare unconstitutional two New York statutes penalizing assistance in suicide to extent that the statutes prohibit physicians from acceding to requests of terminally-ill, mentally competent patients for drugs to hasten death.

Affirmed in part and reversed in part.

Judge Calabresi concurs in a separate opinion.

KATHRYN L. TUCKER, Perkins Coie, Seattle, WA, and CARLA A. KERR, Hughes Hubbard & Reed, New York, NY (David J. Burman, Thomas L. Boeder, Kari Anne Smith, Perkins Coie, Seattle, WA, Leigh A. Roveda, Hughes Hubbard & Reed, New York, NY, of counsel), *for Plaintiffs-Appellants*.

MICHAEL POPKIN, Assistant Attorney General, New York, NY (Dennis C. Vacco, Attorney General of the State of New York, Victoria Graffeo, Solicitor General, Kathie Ann Whipple, Acting Bureau Chief, Litigation Bureau, Susan L. Watson, Assistant Attorney General, of counsel), *for Defendants-Appellees*.

MARC FRAZIER SCHOLL, Assistant District Attorney, New York, NY (Robert M. Morgenthau, District Attorney of New York County, Marc Dwyer, Assistant

District Attorney, of counsel), *for Defendant-Appellee Robert M. Morgenthau*.

(Michael L. Costello, New York State Catholic Conference, Albany, NY, Mark E. Chopko, Michael F. Moses, United States Catholic Conference, Washington, DC, of counsel), for United States Catholic Conference and New York State Catholic Conference as *amici curiae*.

(Michael Tierney, New York, NY, of counsel), for New York State Right to Life Committee, Inc. as *amicus curiae*.

(James Bopp, Jr., Richard E. Coleson, Bopp, Coleson & Bostrom, Terre Haute, IN, of counsel), for The National Right To Life Committee, Inc. as *amicus curiae*.

(Paul Benjamin Linton, Clarke D. Forsythe, Americans United for Life, Chicago, IL, of counsel), for Members of the New York State Legislature as *amici curiae*.

(Cameron Clark, Claudia L. Hammerman, New York, NY, of counsel), for Lambda Legal Defense and Education Fund, Inc., National Association of People with AIDS, Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, Gray Panthers Project Fund, Hemlock Society, and Minna Barrett as *amici curiae*.

MINER, *Circuit Judge*.

Plaintiffs-appellants Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman appeal from a summary judgment entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) dismissing their 42 U.S.C. § 1983 action against defendants-appellees. The action was brought by plaintiffs-appellants, all of whom are physicians, to declare unconstitutional in part two New York statutes penalizing assistance in suicide. The physicians contend that each statute is invalid to the extent that it prohibits them from acceding to the requests of terminally-ill, mentally competent patients for help in hastening death. In granting summary judgment in favor of defendants-appellees, the district court considered and rejected challenges to the statutes predicated upon the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution. *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994). We reverse in part, holding that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.

BACKGROUND

The action giving rise to this appeal was commenced by a complaint filed on July 20, 1994. The plaintiffs named in that complaint were the three physicians who are the appellants here and three individuals then in the final stages of terminal illness: Jane Doe (who chose to conceal her actual identity), George A. Kingsley and William A. Barth. The sole defendant named in that complaint was G. Oliver Koppell, then the Attorney

General of the State of New York. He has been succeeded as Attorney General by Dennis C. Vacco, who has been substituted for him as an appellee on this appeal. According to the complaint, Jane Doe was a 76-year-old retired physical education instructor who was dying of thyroid cancer; Mr. Kingsley was a 48-year-old publishing executive suffering from AIDS; and Mr. Barth was a 28-year-old former fashion editor under treatment for AIDS. Each of these plaintiffs alleged that she or he had been advised and understood that she or he was in the terminal stage of a terminal illness and that there was no chance of recovery. Each sought to hasten death "in a certain and humane manner" and for that purpose sought "necessary medical assistance in the form of medications prescribed by [her or his] physician to be self-administered."

The physician plaintiffs alleged that they encountered, in the course of their medical practices, "mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life." Many of these patients apparently "experience chronic, intractable pain and/or intolerable suffering" and seek to hasten their deaths for those reasons. Mr. Barth was one of the patients who sought the assistance of Dr. Grossman. Each of the physician plaintiffs has alleged that "[u]nder certain circumstances it would be consistent with the standards of [his] medical practice" to assist in hastening death by prescribing drugs for patients to self-administer for that purpose. The physicians alleged that they were unable to exercise their best professional judgment to prescribe the requested drugs, and the other plaintiffs alleged that they were unable to receive the requested drugs, because of the prohibitions contained in sections

125.15(3) and 120.30 of the New York Penal Law, all plaintiffs being residents of New York.

Section 125.15 of the New York Penal Law provides in pertinent part:

> A person is guilty of manslaughter in the second degree when:
>
> . . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

A violation of this provision is classified as a class C felony. *Id.*

Section 120.30 of the New York Penal Law provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

A violation of this provision is classified as a class E felony. *Id.*

Count I of the complaint included an allegation that "[t]he Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives." It also included an allegation that

> [t]he Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

Count II of the complaint included an allegation that

> [t]he relevant portions of . . . the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

In their prayer for relief the plaintiffs requested judgment declaring the New York statutes complained of constitutionally invalid and therefore in violation of 42 U.S.C. § 1983 "as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death." Plaintiffs also sought an order permanently enjoining defendants from enforcing the statutes and an award of attorney's fees.

By order to show cause filed on September 16, 1994, the plaintiffs moved for a preliminary injunction to enjoin then-Attorney General Koppell "and all persons acting in concert and participation with him from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths." A declaration by each of the plaintiffs was submitted in support of the application, although Jane Doe had died prior to the filing of the order to show cause. Plaintiffs Kingsley and Barth were then in the advanced stages of AIDS and therefore sought an immediate determination by the district court.

In her declaration, Jane Doe stated:

> I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is

collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ablity to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough. . . . In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the termnal phase of this disease. . . . At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intenion of hastening my death through the consumption of drugs prescribed for that purpose.

Mr. Kingsley subscribed to a declaration that included the following:

> At this time I have almost no immune system function. . . . My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. . . . I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. . . . I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. . . . I . . . take daily infusions of cytovene for the . . . retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful. . . . At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of [AIDS]. . . . It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable.

In his declaration, Mr. Barth stated:

> In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer. . . . In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. . . . In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. . . . At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion. . . . In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting.

> I have begun to lose bowel control . . . . For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects. . . . While I have tolerated some [nightly intravenous] feedings, I am unwilling to accept this for an extended period of time. . . . I understand that there are no cures. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

A cross-motion for judgment on the pleadings was filed by Attorney General Koppell on October 11, 1994. Thereafter, on October 14, 1994, an amended complaint was filed by the three physicians and Mr. Kingsley naming as defendants Attorney General Koppell and New York State Governor Mario M. Cuomo. The counts of the complaint were the same as set forth in the original complaint, alleging violations of liberty interests guaranteed by the Fourteenth Amendment in Count I and violation of equal protection rights guaranteed by the Fourteenth Amendment in Count II. The prayer for relief remained the same as in the original complaint. Supplemental declarations in support of the plaintiff's motion for preliminary injunction also were filed on October 14, 1994. In their supplemental declarations, Doctors Klagsbrun and Grossman reiterated their desire "to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths."

In his supplemental declaration, Dr. Quill declared:

> The removal of a life support system that directly results in the patient's death requires the direct

> involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments. . . . Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.

Along with the supplemental declarations filed on October 14th, an original declaration in support of the motion was filed by Dr. Jack Froom, a physician and Professor of Family Medicine with substantial experience in detecting depression in primary care patients. He declared:

> Physicians can determine whether a patient's request to hasten death is rational and competent or motivated by depression or other mental illness or instability. Physicians currently make these determinations as to patient capacity to make end-of-life decisions with respect to orders not to resuscitate and refusal of life-sustaining treatment. . . . Terminally ill persons who seek to hasten death by con-

suming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task. . . . It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. . . . Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

A second amended complaint was filed on October 20, 1994. The parties, allegations and prayer for relief were the same as those contained in the first amended complaint, except that Robert M. Morgenthau, District Attorney of New York County, was added as a defendant in his official capacity. Both Dr. Grossman and Dr. Klagsbrun practice medicine in New York City, and Mr. Morgenthau is responsible for the prosecution of crimes occurring in New York County. The physician plaintiffs each filed second supplemental declarations on November 28, 1994, in support of the motion for a preliminary injunction. Each stated that he was currently treating mentally competent, terminally-ill patients who desired to hasten their deaths by self-administering drugs to be provided by the physicians "if and when medically and psychiatrically appropriate." These patients, according to the physicians, understood "their condition, diagnosis, and prognosis and wish[ed] to avoid prolonged suffering by hastening their deaths if and when their

suffering [became] intolerable." None of the three terminally-ill plaintiffs named in the original complaint survived to the date of the district court's decision.

The opinion of the district court was filed on December 16, 1994. The district court denied the motion for a preliminary injunction and granted the defendants' cross motion to dismiss the action, treating the cross motion as one for summary judgment "since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction." *Quill*, 870 F. Supp. at 79. After finding that the action presented a justiciable case or controversy, the district court first addressed the due process issue. The court determined that physician assisted suicide could not be classified as a fundamental right within the meaning of the Constitution:

> The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights "not readily identifiable in the Constitution's text" are deserving of constitutional protection. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions.
>
> The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right.

Id. at 83 (internal citations omitted). Accordingly, the district court concluded "that the type of physician assisted suicide at issue in this case does not involve a

fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment." *Id.* at 84.

Turning to the equal protection issue, the district court identified a reasonable and rational basis for the distinction drawn by New York law between the refusal of treatment at the hands of physicians and physician assisted suicide:

> [I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide.

Id. at 84-85. Accordingly, the court held "that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment." *Id.* at 85.

DISCUSSION

I. Justiciability

As they did in the district court, the state defendants contend on appeal that this action does not present a justiciable case or controversy. We reject this contention.

In *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979), the Supreme Court was faced with a constitutional challenge to an Arizona farm labor statute. The Court stated that, when contesting the constitutionality of a state criminal statute, it is not necessary

that the plaintiff first expose himself to actual prosecution. *Id.* at 298. Rather,

> [w]hen the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder, he "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief."

Id. (quoting *Doe v. Bolton*, 410 U.S. 179, 188 (1973)). The Court in *Doe* held that plaintiff physicians had presented a justiciable controversy despite the fact that none had been threatened with prosecution. 410 U.S. at 188. The law that the physicians challenged was a criminal statute that directly criminalized the physician's participation in abortion. Accordingly, a sufficiently concrete controversy was presented.

The same principles lead to the conclusion that there is a case or controversy at issue here. Dr. Quill has had a criminal proceeding instituted against him in the past, and the state nowhere disclaims an intent to repeat a prosecution in the event of further assisted suicides. The other two physician plaintiffs also face the threat of criminal prosecution. Like the physicians in *Doe*, they "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief." Finally, under *Doe*, the physicians may raise the rights of their terminally-ill patients. *See id.*

Although District Attorney Morgenthau argues in his brief on appeal that appellants have not shown that they are in any jeopardy of prosecution in New York County, a recent indictment by a New York County grand jury

demonstrates the contrary. A newspaper report printed on December 15, 1995 disclosed the following:

> Yesterday, District Attorney Robert M. Morgenthau of Manhattan announced that a grand jury had indicted [George] Delury, an editor who lives on the Upper West Side, on manslaughter charges for helping his 52-year-old wife, Myrna Lebov, commit suicide last summer.

Carey Goldberg, *Suicide's Husband Is Indicted; Diary Records Pain of 2 Lives*, N.Y. Times, Dec. 15, 1995, at B1.[1] The physician plaintiffs have good reason to fear prosecution in New York County.

II. Substantive Due Process

Plaintiffs argue for a right to assisted suicide as a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. This Clause assures the citizenry that any deprivation of life, liberty or property by a state will be attended by appropriate legal processes. However,

> despite the language of the Due Process Clause[ ] of the . . . Fourteenth Amendment[ ], which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which th[at] Clause[ ] ha[s] been interpreted to have substantive content, subsuming rights that to a great extent are immune from . . . state regulation or proscription. Among such cases are those recognizing rights that have little or no textual support in the constitutional language.

---

[1] On March 15, 1996, Delury pleaded guilty to second-degree attempted manslaughter. Pam Belluck, *Man Will Get Prison Term for Helping His Wife Kill Herself*, N.Y. Times, Mar. 16, 1996, at 23, 26.

Bowers v. Hardwick, 478 U.S. 186, 191 (1986).

Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977); *see also Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). It is well settled that the state must not infringe fundamental liberty interests unless the infringement is narrowly tailored to serve a compelling state interest. *Reno v. Flores*, 113 S. Ct. 1439, 1447 (1993). The list of rights the Supreme Court has actually or impliedly identified as fundamental, and therefore qualified for heightened judicial protection, include the fundamental guarantees of the Bill of Rights as well as the following: freedom of association; the right to participate in the electoral process and to vote; the right to travel interstate; the right to fairness in the criminal process; the right to procedural fairness in regard to claims for governmental deprivations of life, liberty or property; and the right to privacy. 2 Ronald D. Rotunda & John E. Nowak, *Treatise on Constitutional Law* § 15.7, at 434-36 (2d ed. 1992). The right of privacy has been held to encompass personal decisions relating to marriage, procreation, family relationships, child rearing and education, contraception and abortion. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977). While the Constitution does not, of course, include any explicit mention of the right of privacy, this right has been recognized as encompassed by the Fourteenth

Amendment's Due Process Clause. *Id.* at 684. Nevertheless, the Supreme Court has been reluctant to further expand this particular list of federal rights, and it would be most speculative for a lower court to do so. *See* Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 15.7, at 433-37.

In any event, the Supreme Court has drawn a line, albeit a shaky one, on the expansion of fundamental rights that are without support in the text of the Constitution. In *Bowers*, the Supreme Court framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time." 478 U.S. at 190. Holding that there was no fundamental right to engage in consensual sodomy, the Court noted that the statutes proscribing such conduct had "ancient roots." *Id.* at 192. The Court noted that sodomy was a common law criminal offense, forbidden by the laws of the original 13 states when they ratified the Bill of Rights, and that 25 states and the District of Columbia still penalize sodomy performed in private by consenting adults. *Id.* at 192-93.

As in *Bowers*, the statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. *See* Thomas J.

Marzen et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 56-67 (1985). Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 55 (1994) ("*When Death Is Sought*"). Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States. *See generally* Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 561 (1995); Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Rep., May-June 1993, at 32.

In rejecting the due process-fundamental rights argument of the plaintiffs, we are mindful of the admonition of the Supreme Court:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.

Bowers, 478 U.S. at 194. The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death. We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow. The limited

room for expansion of substantive due process rights and the reasons therefor have been clearly stated: "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area.

III. Equal Protection

According to the Fourteenth Amendment, the equal protection of the laws cannot be denied by any State to any person within its jurisdiction. U.S. Const. amend. XIV, § 1. This constitutional guarantee simply requires the states to treat in a similar manner all individuals who are similarly situated. *See* 3 Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 18.2, at 7. But disparate treatment is not necessarily a denial of the equal protection guaranteed by the Constitution. The Supreme Court has described the wide discretion afforded to the states in establishing acceptable classifications:

> The Equal Protection Clause directs that "all persons similarly circumstanced shall be treated alike." But so too, "[t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." The initial discretion to determine what is "different" and what is "the same" resides in the legislatures of the States. A legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and

> private, and that account for limitations on the practical ability of the State to remedy every ill. In applying the Equal Protection Clause to most forms of state action, we thus seek only the assurance that the classification at issue bears some fair relationship to a legitimate public purpose.

Plyler v. Doe, 457 U.S. 202, 216 (1982) (internal citations omitted and alteration in original).

The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). In *Cleburne*, the equal protection issue revolved around a zoning ordinance that required a special use permit for homes for the mentally retarded but not for other multiple-dwelling and care-giving facilities. The Supreme Court resolved the issue as follows:

> Because in our view the record does not reveal any rational basis for believing that the Featherston home [for the mentally retarded] would pose any special threat to the city's legitimate interests, we affirm the judgment below insofar as it holds the ordinance invalid as applied in this case.

Id. at 448. In arriving at this conclusion, the Court rejected the city's claims that the disparate classification was justified by the negative attitudes of property owners in the neighborhood of the proposed facility, the location of the facility across the street from a junior high school and on a 500-year flood plain, concerns about legal responsibility for actions that might be taken by the mentally retarded, or concerns about the size of the facility and the number of occupants. *Id.* at 448-50. The Court carefully examined each of these claims

before finding that there was no acceptable reason for the disparate classification in any of them.

Also found invalid under the Equal Protection Clase for failure to survive rational basis scrutiny was a New Mexico statute providing a partial exemption from he state's property tax for certain honorably discharged eterans. *Hooper v. Bernalillo County Assessor*, 472 U.S. 612 (1985). The exemption was limited to veterans who had served on active duty during the Vietnam War fc at least 90 continuous days and were New Mexico residats before May 8, 1976. In finding the residence requement invalid under the Equal Protection Clause, he Court analyzed the New Mexico statute in light of he following principles: "When a state distributes benefits unequally, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive rational scrutiny if the distinction rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted). The Court determined that the distinction made between veterans who arrived in the state prior to May 8, 1976 and those who arrived thereafter bore no rational relationship to the state's declared objectives of encouraging veterans to settle in the state and of rewarding citizens who resided in the state prior to the cut-off date for their military service. *Id.* at 619-20.

As to the first objective, the Court wrote:

> The distinction New Mexico makes between veterans who established residence before May 8, 1976, and those veterans who arrived in the State thereafter bears no rational relationship to one of the State's objectives—encouraging Vietnam veterans to move to New Mexico. The legislature set this eligibility date long after the triggering event

> occurred. The legislature cannot plausibly encourage veterans to move to the State by passing such retroactive legislation.

Id. at 619 (internal citation omitted). As to the second declared objective, the Court noted that a state court may legitimately compensate resident veterans for past services by providing various advantages, but that "the New Mexico statute's distinction between resident veterans is not rationally related to the State's asserted legislative goal." *Id.* at 621-22. The Court held:

> The State may not favor established residents over new residents based on the view that the State may take care of "its own," if such is defined by prior residence. Newcomers, by establishing bona fide residence in the State, become the State's "own" and may not be discriminated against solely on the basis of their arrival in the State after May 8, 1976.

Id. at 623. *See also Zobel v. Williams*, 457 U.S. 55 (1982) (holding that Alaska statute using length of residence as basis for distribution of oil reserve dividends violated Equal Protection Clause.)

While rational basis scrutiny governs judicial review of the constitutionality of legislation in the areas of social welfare and economics, *see Bowen v. Owens*, 476 U.S. 340, 345 (1986), strict scrutiny is the standard of review where a classification "impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class," *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976) (footnotes omitted). Suspect classes are those identified by race, alienage or national origin, *Cleburne*, 473 U.S. at 440, and fundamental rights are those explicitly or implicitly derived from the Constitution itself, *see*

San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33-34 (1973). For the reasons described in Part II, *supra*, the New York statutes prohibiting assisted suicide during the terminal stages of illness do not impinge on any fundamental rights nor can it be said that they involve suspect classifications. Laws subject to strict scrutiny will survive such review only if they are suitably tailored to serve a compelling state interest. *Cleburne*, 473 U.S. at 440.

An intermediate level of scrutiny has been applied in analyzing certain equal protection guarantee violations. To pass this scrutiny, the classification must be substantially related to an important governmental objective. *Clark v. Jeter*, 486 U.S. 456, 461 (1988). This sort of examination has been applied to classifications based on sex or illegitimacy. *Id.*; *see also Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 459 (1988); *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 723-24 (1982). A heightened level of equal protection scrutiny also was applied in *Plyler*, where the Supreme Court struck down a Texas statute withholding from local school districts funding for the education of children not legally admitted into the United States. 457 U.S. at 202.

Applying the foregoing principles to the New York statutes criminalizing assisted suicide, it seems clear that: 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in questions prohibit persons in

the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

The right to refuse medical treatment long has been recognized in New York. In 1914 Judge Cardozo wrote that, under New York law, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129 (1914). In 1981, the New York Court of Appeals held that this right extended to the withdrawal of life-support systems. *In re Eichner* (decided with *In re Storar*), 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858 1981). The *Eichner* case involved a terminally-ill, 83-year-old patient whose guardian ultimately was authorized to withdraw the patient's respirator. The Court of Appeals determined that the guardian had proved by clear and convincing evidence that the patient, prior to becoming incompetent due to illness, had consistently expressed his view that life should not be prolonged if there was no hope of recovery. *Id.* at 379-80. In *Storar*, the companion case to *Eichner*, the Court of Appeals determined that a profoundly retarded, terminally-ill patient was incapable of making a decision to terminate blood transfusions. There, the patient was incapable of making a reasoned decision, having never been competent at any time in his life. *Id.* at 380. In both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so.

The Court of Appeals revisited the issue in *Rivers v. Katz*, 67 N.Y.2d 485 (1986) (establishing the right of mentally incompetent persons to refuse certain drugs). In

that case, the Court recognized the right to bring on death by refusing medical treatment not only as a "fundamental common-law right" but also as "coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Id.* at 493. The following language was included in the opinion:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Id.

After these cases were decided, the New York legislature placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place. In 1987, the legislature enacted Article 29-B of the New York Public Health Law, entitled "Orders Not to Resuscitate." N.Y. Pub. Health Law §§ 2960-79 (McKinney 1993). The Article provides that an "adult with capacity" may direct the issuance of an order not to resuscitate. § 2964. "Order not to resuscitate" is defined as "an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest." § 2961(17). "Cardiopulmonary resuscitation" is defined as "measures . . . to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest." § 2961(4). An elaborate statutory scheme is in place, and it provides, among other things, for surrogate decision-making, § 2965, revocation of consent, § 2969, physician

review, § 2970, dispute mediation, § 2972, and judicial review, § 2973.

In 1990, the New York legislature enacted Article 29-C of the Public Health Law, entitled "Health Care Agents and Proxies." N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993). This statute allows for a person to sign a health care proxy, § 2981, for the purpose of appointing an agent with "authority to make any and all health care decisions on the principal's behalf that the principal could make." § 2982(1). These decisions include those relating to the administration of artificial nutrition and hydration, provided the wishes of the principal are known to the agent. § 2982(2). The agent's decision is made "[a]fter consultation with a licensed physician, registered nurse, licensed clinical psychologist or certified social worker." *Id.* Accordingly, a patient has the right to hasten death by empowering an agent to require a physician to withdraw life-support systems. The proxy statute also presents a detailed scheme, with provisions for a determination that the principal lacks capacity to make health care decisions, for such a determination to be made only by the attending physician in consultation with another physician "[f]or a decision to withdraw or withhold life-sustaining treatment," § 2983, for provider's obligations, § 2984, for revocation, § 2985, and for special proceedings, § 2992, among other matters.

The concept that a competent person may order the removal of life-support systems found Supreme Court approval in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). There the Court upheld a determination of the Missouri Supreme Court that required proof by clear and convincing evidence of a patient's desire for the withdrawal of life-sustaining equipment.

The patient in that case, Nancy Cruzan, was in a persistent vegetative state as the result of injuries sustained in an automobile accident. Her parents sought court approval in the State of Missouri to terminate the artificial nutrition and hydration with which she was supplied at the state hospital where she was confined. The hospital employees refused to withdraw the life-support systems, without which Cruzan would suffer certain death. The trial court authorized the withdrawal after finding that Cruzan had expressed some years before to a housemate friend some thoughts that suggested she would not wish to live on a life-support system. The trial court also found that one in Cruzan's condition had a fundamental right to refuse death-prolonging procedures.

The Missouri Supreme Court, in reversing the trial court, refused to find a broad right of privacy in the state constitution that would support a right to refuse treatment. Moreover, that court doubted that such a right existed under the United States Constitution. It did identify a state policy in the Missouri Living Will Statute favoring the preservation of life and concluded that, in the absence of compliance with the statute's formalities or clear and convincing evidence of the patient's choice, no person could order the withdrawal of medical life-support services.

In affirming the Missouri Supreme Court, the United States Supreme Court stated: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. The Court noted that the inquiry is not ended by the identification of a liberty interest, because there also must be a balancing of the state interests and the individual's liberty interests before there can be a determination that con-

stitutional rights have been violated. *Id.* at 279. The Court all but made that determination in the course of the following analysis:

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Id.

The Court went on to find that Missouri allowed a surrogate to "act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death," subject to "a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent." *Id.* at 280. The Court then held that the procedural safeguard or requirement imposed by Missouri—the heightened evidentiary requirement that the incompetent's wishes be proved by clear and convincing evidence—was not forbidden by the United States Constitution. *Id.* at 280-82.

In view of the foregoing, it seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on

life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs. The district judge has identified "a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Quill*, 870 F. Supp. at 84. But Justice Scalia, for one, has remarked upon "the irrelevance of the action-inaction distinction," noting that "the cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Cruzan*, 497 U.S. at 296-297 (citations omitted and alteration in original) (Scalia, J., concurring). *See also* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2028-31 (1992) (arguing that there is no distinction between assisted suicide and the withholding or withdrawal of treatment).

Indeed, there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in

bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

A finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest. The burden is upon the plaintiffs to demonstrate irrationality. *See Kadrmas*, 487 U.S. at 463. At oral argument and in its brief, the state's contention has been that its principal interest is in preserving the life of all its citizens at all times and under all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. *See In re Quinlan*, 70 N.J. 10, 41, *cert. denied*, 429 U.S. 922 (1976). And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

A panel of the Ninth Circuit attempted to identify some state interests in reversing a district court decision holding unconstitutional a statute of the state of Washington criminalizing the promotion of a suicide attempt. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).[2] The plaintiffs in the Washington case contended for physician-assisted suicide for the terminally-ill, but the panel majority found that the statute prohibiting suicide promotion furthered the following: the interest in denying to physicians "the role of killers of their patients"; the interest in avoiding psychological pressure upon the elderly and infirm to consent to death; the interest of preventing the exploitation of the poor and minorities; the interest in protecting handicapped persons against societal indifference; the interest in preventing the sort of abuse that "has occurred in the Netherlands where . . . legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient." *Id.* at 592-93. The panel majority also raised a question relative to the lack of clear definition of the term "terminally ill." *Id.* at 593.

The New York statutes prohibiting assisted suicide, which are similar to the Washington statute, do not serve any of the state interests noted, in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment. Physicians do not fulfill the role of "killer" by prescribing drugs to hasten death any more than they do by disconnecting life-support systems. Likewise, "psychological pressure" can be applied just as much upon the elderly and infirm

[2] On rehearing in banc, the Ninth Circuit vacated the decision of the panel and affirmed the decision of the district court. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (in banc).

to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. There is no clear indication that there has been any problem in regard to the former, and there should be none as to the latter. In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures. With respect to the protection of minorities, the poor and the non-mentally handicapped, it suffices to say that these classes of persons are entitled to treatment equal to that afforded to all those who now may hasten death by means of life-support withdrawal. In point of fact, these persons *themselves* are entitled to hasten death by requesting such withdrawal and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.

As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so. *When Death Is Sought*, *supra*, at 133-34. The plaintiffs here do not argue for euthanasia[3] at all but for assisted suicide for terminally-ill, mentally competent patients, who would self-administer the lethal drugs. It is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands. Moreover, note should be taken of the fact that the Royal Dutch Medical Associ-

[3] There are those who use the terms "assisted suicide" and "euthanasia" interchangeably. *See* Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 439 n.8 (1992). While euthanasia is derived from the Greek words meaning "good death," *id.* at 441, it seems clear that most states, including New York, make a distinction between the two acts. *See When Death Is Sought*, *supra*, at 63. In euthanasia, one causes the death of another by direct and intentional acts. *Id.* Accordingly, euthanasia falls within the definition of murder in New York. *See* N.Y. Penal Law § 125.25(1) (McKinney 1987).

ation recently adopted new guidelines for those physicians who choose to accede to the wishes of patients to hasten death. Under the new guidelines, patients must self-administer drugs whenever possible, and physicians must obtain a second opinion from another physician who has no relationship with the requesting physician or his patient. Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. Times, Sept. 11, 1995, at A3.

Finally, it seems clear that most physicians would agree on the definition of "terminally ill," at least for the purpose of the relief that plaintiffs seek. The plaintiffs seek to hasten death only where a patient is in the "final stages" of "terminal illness," and it seems even more certain that physicians would agree on when this condition occurs. Physicians are accustomed to advising patients and their families in this regard and frequently do so when decisions are to be made regarding the furnishing or withdrawal of life-support systems. Again, New York may define that stage of illness with greater particularity, require the opinion of more than one physician or impose any other obligation upon patients and physicians who collaborate in hastening death.[4]

[4] For example, the state might take steps to assure the competence of prescribing physicians by imposing education and training qualifications, including pain management; it may require the establishment of local ethics committees as resources for physicians faced with questions relating to requests for lethal medications; it could specify the information to be furnished to the patient to ascertain that the patient's choice is a fully voluntary one; it might require consultations with other physicians for further diagnosis and prognosis in regard to the patient's illness, for psychiatric evaluation, and for evaluation of pain control possibilities; it may provide a time delay between a request for lethal medication and the prescription in order to allow a time for reflection; and it may suggest some sort of notification to the patient's family.

Recently, a group of physicians known as "Physicians for Mercy" proposed ten guidelines for doctor-assisted suicide. *Doctors Offer Some Support to Kevorkian: Urge 10 Guidelines in Assisting Suicide*, N.Y. Times, Dec. 5, 1995, at A21. These guidelines call for a physician who assists in suicide, called an "obitiatrist," to refer his patients to a psychiatrist, a specialist in the patient's specific illness, and, if necessary, a specialist in pain management, before acting at the behest of a mentally competent person with an incurable affliction. *Id.* "Physicians for Mercy" has decided to call the practice of physician assisted suicide "patholysis," a term coined by Dr. Jack Kevorkian, who has assisted in more than two dozen suicides. *Id.* However, Dr. Kevorkian's assistance has not been rendered exclusively to those beset by terminal illnesses. Bruce Fein, *The Right to Determine One's Exit from Life*, Wash. Times, Jan. 23, 1996, at A14.

The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.

CONCLUSION

We reverse the judgment of the district court and remand for entry of judgment in favor of the plaintiffs in accordance with the foregoing. No costs are awarded to either side. *See* Fed. R. App. P. 39(a).

CALABRESI, *Circuit Judge*, concurring in the result:

The Court today strikes down the New York statutes prohibiting assisted suicide insofar as they apply to "terminally ill, mentally competent patients, who would self-administer drugs." It does so because it finds these statutes to be in violation of the Equal Protection Clause of the Fourteenth Amendment since they are not "ratio-

nally related to a legitimate state interest." *Ante* at 20 (citing *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985)). At the same time, the Court declines to hold that these statutes violate the Due Process Clause of the Fourteenth Amendment, because "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design." *Ante* at 18.

Recently the Ninth Circuit, sitting *en banc*, held that analogous laws violated the fundamental Due Process rights of terminally ill patients. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (*en banc*). The Ninth Circuit recognized that Equal Protection arguments for invalidity were "not insubstantial," but did not discuss them in view of its Due Process holding. *Id.* at *39 n.139.

I agree with the Court that these statutes cannot stand. But I do not believe that the history of the statutes, and of New York's approach toward assisted suicide, requires us to make a final judgment under either Due Process or Equal Protection as to the validity of statutes prohibiting assisted suicide. What is not ready for decision ought not to be decided. I would therefore leave open the question of whether, if the state of New York were to enact new laws prohibiting assisted suicide (laws that either are less absolute in their application or are identical to those before us), such laws would stand or fall.

Accordingly, I join the Court's result, but write separately to explain my unwillingness to reach the ultimate Due Process and Equal Protection questions.

I. *A Bit of History*

There once was a time when the law and its judges were not called upon to make choices for human beings lying in the twilight between life and death. In the past, many of these decisions were left to individual doctors and their patients. Sometimes, easing of pain melded, not quite imperceptibly, into more. While doctors did not advertise their availability, there often was an understanding (perhaps unspoken), as patients entered into what usually were long-term relationships with physicians, that when the time came doctors would do what was expected of them. Laws prohibiting assisted suicide were on the books. But whether they were ever meant to apply to a treating physician, or whether such doctors were even slightly concerned about them, is unclear and lost in the shadows of time.[1] And despite a web of statutes, and doctors who, understandably, have become increasingly averse to taking risks and responsibilities, that tradition undoubtedly continues today. As the majority demonstrates, however, this fact is not a prescription for judicial silence. *Ante* at 13-15. We must, therefore,

[1] *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 57 (1994) ("No person has been convicted in New York State of manslaughter for intentionally aiding or causing a suicide. . . . The reluctance to bring such cases no doubt rests in part on the degree of public sympathy [such cases] often arouse, and the resulting difficulty of securing an indictment and conviction."); *Compassion in Dying*, 1996 WL 94848, at *17 (footnotes omitted) ("[T]he mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death. . . . Running beneath the official history of legal condemnation of physician-assisted suicide is a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths.").

address petitioners' claim that New York's laws are invalid.

The statutes at issue were born in another age. New York enacted its first prohibition of assisted suicide in 1828. The statute punished any individual who assisted another in committing "self-murder" for first-degree manslaughter. Act of Dec. 10, 1828, ch. 20, 4 1828 N.Y. Laws 19 (codified at N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7 (1829)). This prohibition was tied to the crime of suicide, described by one contemporary New York Court as a "criminal act of self-destruction." *Breasted v. Farmers' Loan & Trust Co.*, 4 Hill 73, 75 (Sup. Ct. 1843), *aff'd*, 8 N.Y. 299 (1853).

English authorities had long declared suicide to be murder. *See* 3 EDWARD COKE, INSTITUTES OF THE LAWS OF ENGLAND 54 (London, E. & R. Brooke 1797) (1644); 1 MATTHEW HALE, PLEAS OF THE CROWN 411-18 (London, E. & R. Nutt 1736) (1680); 4 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND *189 (1769); 3 JAMES FITZJAMES STEPHEN, HISTORY OF THE CRIMINAL LAW OF ENGLAND 104 (1869); William E. Mikell, *Is Suicide Murder?*, 3 COLUM. L. REV. 379, 391 (1903) ("[W]hatever may have been the law before Bracton's time . . . suicide is murder in English law."). And the leading American case echoed these English authorities. *See Commonwealth v. Bowen*, 13 Mass. 356 (1816). In that case, Chief Justice Parker instructed the jury: "Self-destruction is doubtless a crime of awful turpitude; it is considered in the eye of the law of equal heinousness with the murder of one by another. In this offence, it is true the actual murderer escapes punishment; for the very commission of the crime, which the the [sic] law would otherwise punish with its utmost rigor, puts the offender beyond the reach of its

infliction. And in this he is distinguished from other murderers. But his punishment is as severe as the nature of the case will admit; his body is buried in infamy, and in England his property is forfeited to the King." *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (reprinting Parker's jury instructions in *Bowen*). *Mink* itself, written by Chief Justice Gray, found that "any attempt to commit" suicide is "unlawful and criminal." *Id.* at 429.

Four years after *Mink*, however, the New York Legislature revised the Penal Code. The new code provided that an intentional *attempt* to commit suicide was a felony with a maximum penalty of two years' imprisonment. Act of July 26, 1881, ch. 676, §§ 174, 178, 3 1881 N.Y. Laws 42-43. But while the Code declared suicide itself to be "a grave public wrong," it imposed no forfeiture because of "the impossibility of reaching the successful perpetrator." *Id.* § 173. The 1881 statute, echoing the earlier 1828 provision, punished assisting a successful suicide as manslaughter in the first degree. *Id.* § 175. The Code also punished assistance in attempted suicide as an unspecified felony. *Id.* § 176.

Whatever may have been the case in other jurisdictions,[2] the 1828 and 1881 statutes prohibited all attempts to assist in a suicide on the theory that such behavior created accessory liability. Thus, because attempted suicide was a crime, assisting in the commission of suicide was also a crime. And the titles of the sections of the 1881 statute manifest these derivative origins; section 175 prohibited "*Aiding* suicide" and section 176 prohibited "*Abetting* an attempt at suicide." *Id.* (emphasis added).[3]

---

[2] *See Compassion in Dying*, 1996 WL 94848, at *48-*49 (Beezer, J., dissenting).

[3] The 1937 New York Report of the Law Revision Commission explicitly found that "[t]he history of the [abetting and advising suicide] pro-

Whether these laws applied to a doctor who eased or hastened the death of a terminally ill patient is, of course, quite another matter, and one on which the evidence is scant.[4]

The 1881 scheme was altered in 1919 when the prohibition against attempted suicide (originally found in sections 174 and 178) was removed. Act of May 5, 1919, ch. 414, § 1, 2 1919 N.Y. Laws 1193. The Legislature, nevertheless, left in place the declaration of suicide as a "grave public wrong." *See Hundert v. Commercial Travelers Mut. Accident Ass'n of Am.*, 244 A.D. 459, 460, 279 N.Y.S. 555, 556 (1st Dep't 1935) (per curiam) ("[S]uicide, although recognized as a grave public wrong, is not a crime."). And the prohibition of assisting suicide also remained on the books. But we have found no case in which a physician aiding a person who wished to commit suicide was, in fact, penalized in New York after 1919.

In 1965, the Legislature took the next step and deleted the declaration that suicide was a "grave public wrong."[5]

vision is traceable into the ancient common law when a suicide or *felo de se* was guilty of a crime punishable by forfeiture of his goods and chattels. One who encouraged or aided him was guilty as an accessory to the crime of 'self-murder'. . . ." STATE OF NEW YORK, REPORT OF THE LAW REVISION COMMISSION FOR 1937, at 830 (1937).

4 *See supra* note 1.

5 The 1965 Act did provide that "[a] person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 2355 (codified at N.Y. Penal Law § 35.10(4)). *See Von Holden v. Chapman*, 87 A.D.2d 66, 68, 450 N.Y.S.2d 623, 626 (4th Dep't 1982) (upholding order authorizing forced feeding of John Lennon's murderer, Mark David Chapman, to prevent Chapman from starving himself to death because "[t]he preservation of life has a high social value in our culture").

It, however, left in place redrafted versions of sections 175 and 176 of the 1881 Code, stating: "A person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide," § 125.15(3), and, "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide," § 120.30.[6]

The years since 1965 have brought further erosion in the bases for prohibiting assisted suicide with respect to terminally ill persons. Thus, in 1981, the New York Court of Appeals declared that "a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment." *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981). The court applied this principle both to the withdrawal of life-support and to the refusal of blood transfusions. *Id.* at 379-80. Furthermore, in 1986, the court stated: "In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment . . . ." *Rivers v. Katz*, 67 N.Y.2d 485,

6 Why the legislature left the prohibition of assisted suicide in the law, and whether it thought about the issue at all is hard to say. The 1937 Law Revision Report had, in a sense, presaged the event when it said that since New York had removed "all stigma [of suicide] as a crime" and that "[s]ince liability as an accessory could no longer hinge upon the crime of a principal, it was necessary to define it as a substantive offense." REPORT OF THE LAW REVISION COMMISSION, *supra* note 3, at 831. The Commission seemed to have been concerned primarily with those who talked others into killing themselves. It noted the important difference between aiding someone who had a mind-set to commit suicide and the "more dangerous" person "working upon the mind of a susceptible person to induce suicide," *id.* at 832.

493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986). Lower courts, understandably, followed suit. *See Delio v. Westchester County Medical Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) ("[T]he common-law right of self determination with respect to one's body also forms the foundation for a competent adult patient's right to refuse life-sustaining treatment even if the effect is to hasten death . . . .").

The New York Legislature itself acted accordingly. In the 1987 Orders Not to Resuscitate Act, it provided that an "adult with capacity" may create an "order not to resuscitate" in the event the patient "suffers cardiac or respiratory arrest." Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 3140 (codified as amended at N.Y. Pub. Health Law, §§ 2960-2979 (McKinney 1993 & Supp. 1996)). In the 1990 Health Care Agents and Proxies Act, it went further and permitted a competent person to designate an agent who has "authority to make any and all health care decisions on the principal's behalf that the principal could make." Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The statute explicitly stated that choices regarding the withdrawal of artificial nutrition and hydration are within the purview of a health care agent when the wishes of the principal are reasonably known to the agent. N.Y. Pub. Health Law § 2982(2).[7]

[7] The 1990 Act provided the following caution: "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." N.Y. Pub. Health Law § 2989(3). The full significance of this section is not clear. It understandably limited the agent to doing those acts to which the principal, on whose behalf the agent is acting, could consent. It also seemed to leave in place the *status quo* both as to those acts, like suicide, which were no longer crimes and those, like assisted

Later, in 1994, the New York Task Force on Life and the Law, a group organized in 1985 at the request of Governor Cuomo and composed of doctors, bioethicists, and religious leaders, among others, prepared a report on the question. The report, in effect, said leave things as they are: permit suicide and attempted suicide, recognize the right of competent terminally ill patients—either on their own or through agents—to order the ceasing of nutrition and hydration and the withdrawal of life support systems, but do not alter the law to permit what petitioners seek today. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 142-46 (1994). The Legislature received the report and, not surprisingly, took no action, then or since.

From this historical survey, I conclude that 1) what petitioners seek is nominally still forbidden by New York statutes; 2) the bases of these statutes have been deeply eroded over the last hundred and fifty years; and 3) few of their foundations remain in place today.

Specifically:

• The original reason for the statutes—criminalizing conduct that aided or abetted other crimes—is long since gone.

• The distinction that has evolved over the years between conduct currently permitted (suicide, and aiding someone who wishes to die to do so by removing

suicide, which nominally were. But the section did not go further, as New York claims in a letter brief where it says, citing § 2989(3), that "New York's legislature expressly rejected permitting physician assisted suicide." Section 2989(3) did not speak to this any more than it spoke to the legality of suicide.

hydration, feeding, and life support systems) and conduct still prohibited (giving a competent, terminally ill patient lethal drugs, which he or she can self-administer) is tenuous at best.[8]

• The Legislature—for many, many years—has not taken any recognizably affirmative step reaffirming the prohibition of what petitioners seek.

• The enforcement of the laws themselves has fallen into virtual desuetude—not so much as to render the case before us nonjusticiable, but enough to cast doubt on whether, in a case like that which the petitioners present, a prosecutor would prosecute or a jury would convict. And this fact by itself inevitably raises doubts about the current support for these laws.[9]

II. *Constitutional Doubts*

In the case of ordinary legislation none of this would matter much. We regularly uphold laws whose original reason has vanished, whose fit with the rest of the legal system is dubious, whose enforcement is virtually nil, and whose continued presence on the books seems as much due to the strong inertial force that the framers of our constitutions gave to the *status quo* as to any current

---

8 *See ante* at 29-34 (the majority opinion's powerful discussion of the weakness of the distinction).

9 We note in passing that a jury in Michigan recently acquitted Dr. Jack Kevorkian after he argued (despite his earlier, quite explicit, publicity and statements) that all he was doing was ending pain. *See* Todd Nissen, *Kevorkian Found Not Guilty in Assisted Suicide Trial*, Reuters, Mar. 8, 1996. We note also that Iowa has just enacted a law forbidding assisted suicide and that this law does not prohibit "the responsible actions of a licensed health professional to administer pain medication to a patient with a terminal illness." *See Gov. Branstad Signs Bill Outlawing Assisted Suicide*, BNA Health Care Daily, Mar. 5, 1996.

majoritarian support. In a different context, I have argued that courts have used subterfuges and aggressive interpretations to rid the system of such laws. *See* GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 163-66, 172-77 (1982). But I have also criticized such judicial action, at least in the absence of express legislative sanction. *See id.; Taber v. Maine*, 67 F.3d 1029, 1039 (2d Cir. 1995).

When legislation comes close to violating fundamental substantive constitutional rights or to running counter to the requirements of Equal Protection, however, there is, as I hope to demonstrate, a long tradition of constitutional holdings that inertia will not do. In such instances, courts have asserted the right to strike down statutes and, before ruling on the ultimate validity of that legislation, to demand a present and positive acknowledgment of the values that the legislators wish to further through the legislation in issue. And so it is to an examination of the substantive constitutional dubiety of the laws before us that I now turn.

There can be no doubt that the statutes at issue come close—at the very least—to infringing fundamental Due Process rights and to doing so in ways that are also suspect under the antidiscrimination principles of the Equal Protection Clause. While differing in emphasis, the various opinions of the Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), and in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), as well as the *en banc* opinion of the Ninth Circuit in *Companion in Dying*, and the strongly argued majority opinion in this case, make that abundantly clear.

In *Cruzan*, the Court examined whether guardians could order withdrawal of an incompetent patient's life support when, contrary to the requirements of the State of Missouri, there was not clear and convincing proof of the patient's wish to have life support withdrawn. In deciding that the guardians could not so order, the majority opinion noted that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." 497 U.S. at 278. It went on to describe the decision to withdraw life support as "deeply personal" and noted that "[i]t cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." *Id.* at 281.

Various Justices expanded on this theme. Justice O'Connor, concurring, wrote, "I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, see *ante*, at 278-79, and that the refusal of artificially delivered food and water is encompassed within that liberty interest. See *ante*, at 279." *Id.* at 287. She then added, "Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289. Justice Brennan, joined by Justices Marshall and Blackmun, dissenting, made a similar point: "Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence." *Id.* at 310-11. In turn, Justice Stevens, also dissenting, powerfully noted: "Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental . . . .' " *Id.* at 343.

Even Justice Scalia, who was the only member of the Court to find that no liberty interest was implicated, recognized that such issues touch the essence of our humanity. He argued that the Constitution was silent on the question of whether one had a liberty interest in refusing life support, and that such a right could not be found in our history and tradition. *Id.* at 293-96 (Scalia, J., concurring). He then went on to say: "Are there, then, no reasonable and humane limits that ought not to be exceeded in requiring an individual to preserve his own life? There obviously are, but they are not set forth in the Due Process Clause. What assures us that those limits will not be exceeded is the same constitutional guarantee that is the source of most of our protection—what protects us, for example, from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day, none of which horribles are categorically prohibited by the Constitution. Our salvation is the Equal Protection Clause, which requires the democratic majority to accept for themselves and their loved ones what they impose on you and me." *Id.* at 300. Significantly, as the majority today points out, Justice Scalia also made clear that he recognized no sensible difference between assisted suicide (of the sort involved in the case before us) and assisted removal of life support and feeding tubes.

"[T]he cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Id.* at 295-97 (Scalia, J., concurring).

Although the Court in *Cruzan* did not ultimately decide whether a patient had a constitutionally protected right to die, the majority opinion clearly recognized that any infringement of such a liberty interest was at least constitutionally suspect.[10] It said, "Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279.

What is more, the Court in *Cruzan* did not merely "assume" that a liberty interest in refusing life-sustaining medical treatment existed. It found that a prohibition of life-support termination would deprive a patient of that liberty interest. In doing so, the Court noted that

10 Both Justices O'Connor and Scalia joined Chief Justice Rehnquist's opinion, making it an opinion for the Court. Their own concurring opinions, however, gave significantly different glosses to the Court's opinion. *See Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring) ("As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. See *ante*, at 278-279"); *id.* at 293 (Scalia, J. concurring) ("While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field . . . .").

"determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry," and that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.* at 279 (internal quotation marks and citation omitted). It then "assumed" that when a patient's liberty interest was balanced against Missouri's interest in life, the balance would come out in favor of the patient.

Cruzan never actually struck this balance, of course, because the Court found that Missouri could insist on strong evidentiary requirements to ensure that Cruzan wanted to die, since "the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment," *id.* at 281. But this in no way undermines *Cruzan*'s holding that in determining whether a patient has a constitutional right to die, we are required to "balance" the consequences of the state's prohibition of life-support termination against the state's interest in preserving life. *Id.* at 279.

Cruzan, therefore, teaches us that statutes that interfere with an individual's decision to terminate life are suspect under the Due Process Clause. The right to act on that decision is one that may or may not receive ultimate constitutional protection, however, depending on the power of the state's interests and the clarity with which those interests are expressed. Moreover, as Justice Scalia in his concurrence points out, the Equal Protection Clause also requires courts to examine whether such statutes apply equally to "you and me"—regardless of whether the prohibited activity interferes with a fundamental right or disadvantages a suspect class.

Like *Cruzan*, *Casey* suggests that New York's assisted suicide statutes are of doubtful constitutionality. In

Casey, the Court noted that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" and that "the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity." 505 U.S. at 851, 849. In this respect, *Casey* borrowed from Justice Harlan's formulation in *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting), 505 U.S. at 848-49, and defined liberty interests to include choices at the core of human existence. Following Harlan, it stated: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence . . . . Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* at 851.

Today's majority and the Ninth Circuit, *en banc*, in *Compassion in Dying*, go further than the Supreme Court did in *Cruzan* and *Casey*. These circuits—the first to rule on the matter—hold that laws prohibiting physicians from assisting suicide in some circumstances actually violate the Constitution. The majority does so because it can see no valid Equal Protection difference between the so-called "passive" assistance that New York allows and the "active" assistance that New York purports to forbid. The Ninth Circuit, instead, finds a violation of a fundamental Due Process right.[11]

[11] And some distinguished scholars agree. *See, e.g.*, Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-95 (1989) ("If the decision to live or die is said to be so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life support but denied to all other individuals."). There are, of course, distinguished scholars who disagree. *See, e.g.*, Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 DETROIT MERCY L. REV. 735, 753-60 (1995).

In light of these opinions, I believe that it cannot be denied that the laws here involved, whether tested by Due Process or by Equal Protection, are highly suspect. It is also the case, however, that neither *Cruzan*, nor *Casey*, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws invalid. What, then, should be done?

III. *The Constitutional Remand*

I contend that when a law is neither plainly unconstitutional (because in derogation of one of the express clauses of our fundamental charter or, for that matter, of the more general clauses, as these have been interpreted in our constitutional history and traditions), nor plainly constitutional, the courts ought not to decide the ultimate validity of that law without current and clearly expressed statements, by the people or by their elected officials, of the state interests involved. It is my further contention, that, absent such statements, the courts have frequently struck down such laws, while leaving open the possibility of reconsideration if appropriate statements were subsequently made.

Thus, in *Kent v. Dulles*, 357 U.S. 116, 129 (1958), in striking down a State Department directive limiting citizens' passport rights, the Supreme Court, said: "Where activities or enjoyment, natural and often necessary to the well-being of an American citizen, such as travel, are involved, we will construe narrowly all delegated powers that curtail or dilute them. We hesitate to find in this broad generalized power an authority to trench so heav-

ily on the rights of the citizen. . . . Thus we do not reach the question of constitutionality. We only conclude that § 1185 and § 211a do not delegate to the Secretary the kind of authority exercised here." And in *Greene v. McElroy*, 360 U.S. 474 (1959), in voiding a loyalty-security program that did not provide for confrontation of witnesses, the Court stated: "[Legislative and executive decisions] must be made explicitly not only to assure that individuals are not deprived of cherished rights under procedures not actually authorized, but also because explicit action, especially in areas of doubtful constitutionality, requires careful and purposeful consideration by those responsible for enacting and implementing our laws." *Id.* at 507 (citation omitted)

The same view was expressed even by the great constitutional absolutist, Justice Hugo L. Black. In *Barenblatt v. United States*, 360 U.S. 109 (1959), in dissent, he argued that the authority of the House UnAmerican Activities Committee to investigate communism in education should be limited, "[f]or we are dealing here with governmental procedures which the Court itself admits reach to the very fringes of congressional power. In such cases more is required of legislatures than a vague delegation to be filled in later by mute acquiescence." *Id.* at 139-40 (footnote omitted).[12]

While these earlier cases leaned in part on statutory interpretation or on broad readings of doctrines such as

12 The Court's opinion in *Kent* and Justice Black's dissent in *Barenblatt* relied in part on a pair of delegation opinions by Chief Justice Hughes dating from the 1930s. These were treated as using a similar approach because, in the 1930s, the statutes at issue were at the fringes of congressional power under the Commerce Clause. *See Kent*, 357 U.S. at 129 (citing *Panama Refining Co. v. Ryan*, 293 U.S. 388, 420-30 (1935)); *Barenblatt*, 360 U.S. at 140 n.7 (Black, J., dissenting) (citing *Panama Refining* and *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 (1935)).

delegation and vagueness, more recent opinions have applied constitutional remands directly.[13] In *Califano v. Goldfarb*, 430 U.S. 199 (1977), for example, Justice Stevens provided the swing vote in the Court's five-to-four decision that the Social Security Act's grant of special benefits to widows was in violation of Equal Protection. He found that the law discriminated "against a group of males [and] is merely the accidental byproduct of a traditional way of thinking about females." *Id.* at 233 (Stevens, J., concurring). Significantly, he went on to say that "[p]erhaps an actual, considered legislative choice would be sufficient to allow this statute to be upheld, but that is a question I would reserve until such a choice has been made." *Id.* at 223 n.9.[14]

13 Interpretation to avoid constitutional questions and undue delegation have proven particularly useful to the Supreme Court as ways of sending back for a second look federal statutes that came close to infringing fundamental rights. These devices, however, are either not available or are problematic when the statute that skates close to a constitutional line is a state law, since both what can and cannot be delegated within a state and how a state statute should be interpreted are paradigmatic issues of state law. *Compare Sweezy v. New Hampshire*, 354 U.S. 234, 254 (1957) (plurality opinion applying a concept akin to undue delegation to find that "[t]he lack of any indications that the legislature wanted the information the Attorney General attempted to elicit from petitioner must be treated as the absence of authority. It follows that the use of the contempt power . . . was not in accordance with . . . due process") *with id.* at 257 (Frankfurter, J., concurring in the result) (disagreeing with plurality on this issue because "whether the Attorney General of New Hampshire acted within the scope of the authority given him by the state legislature is a matter for the decision of the courts of that State, as it is for the federal courts to determine whether an agency to which Congress has delegated power has acted within the confines of its mandate"). In such circumstances, a reconsideration can occur at the behest of a federal court only if that court is willing impose a constitutional remand directly. *See infra* (discussion of *Thompson v. Oklahoma*, 487 U.S. 815 (1988), and *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972)).

14 The other four votes in the majority held that the statute was an invalid discrimination against women. *Califano*, 430 U.S. at 217 (plurality opinion).

The powerful, and telling, concurring opinion by Justice O'Connor in *Thompson v. Oklahoma*, 487 U.S. 815 (1988), which provided the fifth vote to strike down state death penalty laws applicable to minors less than sixteen years of age, did the same thing. The fact that such laws were on the books in many states did not suffice to meet the strictures of the Cruel and Unusual Punishment Clause. The laws may have been there inadvertently or as a result of inertia, and many state legislatures seemed not to have realized that children could be executed under their statutes. Such laws, moreover, were virtually never enforced against minors under sixteen. Hence, the Justice reasoned, they were invalid. But if states reenacted them, consciously and clearly, the Court would then have to consider whether the statutes could actually meet the Clause's requirements. *Id.* at 857 (O'Connor, J., concurring in the judgment).

Perhaps the most dramatic instance of this constitutional remand, or second look, approach occurred in our own Circuit, in a case bearing many similarities to the one before us today. In *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972) ("*Abele I*"), a three-judge district court was asked to examine the constitutionality of a Connecticut statute that banned abortion. Circuit Judge J. Edward Lumbard found the statute to be unconstitutional for reasons later echoed by the Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973). District Judge T. Emmet Clarie found no violation of due process for reasons akin to those adverted to in today's majority opinion. The key vote was by then-District Judge Jon Newman.

In his landmark opinion, now-Chief Judge Newman found that the Connecticut statute had been passed in 1860 to protect the health of pregnant women, and that

this aim was no longer applicable in 1972 because childbirth endangered a woman's life more than abortion did. *Id.* at 807-09 (Newman, J., concurring). Yet he recognized that other valid grounds for the statute might exist, including, perhaps, the protection of unborn life (*Roe v. Wade* had not yet been decided). Newman pointed out, however, that the statute was not passed to protect unborn life. "If the Connecticut legislature had made [such] a judgment," Newman mused, "the constitutionality of such laws would pose a legal question of extreme difficulty . . . ." *Id.* at 810. Because "that legislative determination has not been shown to have been made," Newman found it "inappropriate to decide the constitutional issue that would be posed" if the Legislature in fact passed a law designed to protect human life. *Id.* And since the statute before him, whatever its basis, raised strong constitutional doubts, Newman nullified the law while explicitly leaving the Legislature free to reconsider the issue.

Judge Newman's opinion is, of course, not binding on us. But it remains an important beacon suggesting what is the correct approach in extremely difficult cases in which neither the Supreme Court, nor constitutional language or tradition, gives clear guidance. It tells us how to deal with situations in which the state interests that might support such statutes can only be inferred from legislative inaction or from long-abandoned legislative motives.

Today, Timothy Quill takes the place of Janice Abele in challenging another statute of nineteenth-century origin. As with the Connecticut abortion law, the rationale for the New York assisted-suicide prohibition has eroded with the passage of time. In the nineteenth century, both suicide and attempted suicide were crimes and assisting

in those crimes was, derivatively, a crime as well. But suicide and attempted suicide are no longer crimes. Nevertheless, the prohibitions on assisted suicide might serve other valid ends. It is possible, for example, to imagine a state in which such statutes were part of an overall approach to the preservation of life that was so all-encompassing that the laws' validity might be upheld despite their infringement of important libertarian individual rights. Our Constitution gives us no more complete dominion over our bodies than it does over our property. *See, e.g., Schmerber v. California*, 384 U.S. 757 (1966) (holding that a state may, over a suspect's protest, have a physician extract blood from a person suspected of drunk driving). In other words, our Constitution does not enact the bodily equivalent of Herbert Spencer's Social Statics. *Cf. Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting). But there is no sign that such an overall "culture of life" reigns in New York State—quite the contrary.

Well before *Roe v. Wade*, New York enacted one of the most permissive abortion laws in the country. *See Roe*, 410 U.S. 113, 147-48 & n.41 (1973). New York recently reenacted the death penalty. *See* Act of Mar. 7, 1995, ch. 1, § 2, 1995 N.Y. Laws 1 (McKinney's) (codified at N.Y. Penal Law § 60.06 (McKinney's Supp. 1996)). As far as I know, no New York Legislature has seriously considered requiring individuals to give their blood, bone marrow or other organs, to keep those who need transplants alive. Indeed, such an idea would strike many as bizarre science fiction. Nearer to hand, the right to demand to die, as and when one wishes, has been recognized in New York for all those on feeding or hydration tubes or on other life support devices. All this the majority opinion demonstrates beyond peradventure.

Various *amici* for the respondents argue that the New York assisted suicide laws consciously adopt their particular vision of what life and death should be. *Amicus* United States Catholic Conference, for example, insists that suicide is antithetical to freedom, that it is not voluntary and that it is linked to psychiatric illness. But there is no reason to believe that New York has accepted these arguments. If it had, one would expect that New York would prohibit attempted suicide and that it would, for example, aggressively discourage suicide by the terminally ill, through legislative declarations defining it to be a "grave public wrong" or through some other means.

Other *amici* contend that the difference between what they call "active" assisted suicide (making lethal drugs available to those terminally ill who would self-administer them) and what they call "passive" behavior (actively removing life supports or feeding tubes, on demand, so that the patient may die) is fundamental. Even if I were to accept the distinction in the face of the powerful arguments made against it both by the majority today and by Justice Scalia in his *Cruzan* concurrence, there is no reason to believe that New York has consciously made such a judgment. Certainly New York has never enacted a law based on a reasoned defense of the difference.

The Attorney General of New York contends that its Legislature has, in fact, made just such a distinction by its inaction, by its failure to remove the prohibitions before us today. It left these in place after the prohibition on what could be called "passive" assisted suicide had been abrogated. Leaving aside the difficulties involved in arguing that legislative *inaction* should be given the *same* weight as legislative *action* in supporting the view that medical *action* and medical *inaction* are funda-

mentally *different*, the argument will not do. As the majority points out, we have not been given any clear statements of possible interests that the state actually believes would be served by the distinction. In their absence, how can we say that the distinction, which is anything but obvious, and which results in severe harm to the ability of some, but not all, individuals to determine crucial life and death choices for themselves, is mandated by the state's fundamental needs? And if the state does not affirmatively tell us what it wishes to put on the other side of the scale, how can we make the balance required by *Cruzan* come out any way but in favor of an individual's freedom to choose between life and death? Whether under Equal Protection, or Due Process, then, the absence of a recent, affirmative, lucid and unmistakable statement of why the state wishes to interfere with what has been held by the Supreme Court to be a significant individual right, dooms these statutes.

I take no position on what I would hold were such an affirmative statement forthcoming from the state of New York. In the wake of *Furman v. Georgia*, 408 U.S. 238, 239-40 (1972) (per curiam), which in effect sent all of the then-existing death penalty laws back for a second look by the states, the Supreme Court (rightly or wrongly) upheld most of the somewhat modified and subsequently enacted death penalty laws. *See Gregg v. Georgia*, 428 U.S. 153, 179-81 (1976) (plurality opinion). Conversely, one month after Judge Newman's concurrence in *Abele I*, Connecticut enacted a new anti-abortion law that was based on protecting the life of the fetus. Pub. Act No. 1, 1972 Conn. Acts 593 (May Spec. Sess.) (codified at Conn. Gen. Stat. § 53-30(a)-(b)). And the same panel that had decided *Abele I* (rightly or

wrongly) declared the new law unconstitutional.[15] Either result is possible after a second look in which the state affirms laws that it previously had allowed to remain in force through passivity or inertia.[16] What I do say is that no court need or ought to make ultimate and immensely difficult constitutional decisions unless it knows that the state's elected representatives and executives—having been made to go, as it were, before the people—assert through their actions (not their inactions) that they really want and are prepared to defend laws that are constitutionally suspect.

It is different when the Constitution speaks clearly. When a law violates the plain mandates of the text, history, or structure of the Constitution, no second look is warranted or appropriate. That law *must* fall. Laws that violate the core of the First Amendment and the core of the Takings Clause are but two examples. When that is not the case, when the Constitution and its history do not clearly render a statute invalid, when its validity depends instead, in part, on the strength of the state interests at

---

15 *See Abele v. Markle*, 351 F. Supp. 224, 232 (D. Conn. 1972) ("*Abele II*"). Then-District Judge Newman's opinion noted that, "for the author of this opinion," the Legislature's new "statement of legislative purpose makes the issue posed . . . quite different from the issue raised by the challenge to the prior statutes. . . . A statute of this sort, as I previously indicated [in *Abele I*], 342 F. Supp. at 810 and 811 n.18, poses a far more difficult question, one that I did not believe should be decided unless such a statute was enacted." *Id.* at 226 n.4. Judge Newman's opinion was joined by Judge Lumbard, while Judge Clarie dissented. The Supreme Court subsequently vacated the decision in light of *Roe*, 410 U.S. 951 (1973), and remanded the case to the district court. On remand, the same three judges declared the law unconstitutional. *Abele v. Markle*, 369 F. Supp. 807, 809 (D. Conn. 1973) (per curiam).

16 Sometimes, of course, a legislature will not reenact a statute that has been remanded to it, or will reenact it with modifications and limits sufficient to avoid any serious constitutional challenge.

stake, then a second look is not only appropriate, it is, in my view, usually required.

Without a second look by the people, courts are liable to err in either direction. They may uphold and thereby validate[17] (as they all too often have[18]) the infringement of rights upon which the states did not truly wish to encroach. Conversely, they may, ultimately and definitively, strike down laws, believing that the state interests involved are minor, when in fact these interests turn out to be highly significant.[19]

In the end, a constitutional remand does no more than this: It tells the legislatures and executives of the various states, and of the federal government as well, that if they wish to regulate conduct that, if not protected by our Constitution, is very close to being protected, they must do so clearly and openly. They must, in other words, face the consequences of their decision before the people.[20] Unless they do this, they cannot expect courts

17 *See* CHARLES L. BLACK, JR., THE PEOPLE AND THE COURT: JUDICIAL REVIEW IN A DEMOCRACY 52 (1960) ("[T]he Court, through its history, has acted as the legitimator of the government. In a very real sense, the Government of the United States is based on the opinions of the Supreme Court.").

18 *See* Guido Calabresi, *The Supreme Court, 1990 Term—Foreword: Antidiscrimination and Constitutional Accountability (What the Bork-Brennan Debate Ignores)*, 105 HARV. L. REV. 80, 143-45 (1991).

19 *See* Harry Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221 (1973); Alexander Bickel & Harry Wellington, *Legislative Purpose and the Judicial Process: The* Lincoln Mills *Case*, 71 HARV. L. REV. 1 (1957); Alexander Bickel, *The Supreme Court, 1960 Term—Foreword: The Passive Virtues*, 75 HARV. L. REV. 40 (1961).

20 In this respect, the notion of a constitutional remand may respond to some of the concerns expressed by the dissenters in *Companion in Dying*. *See Compassion in Dying*, 1996 WL 94848, at *60 (Beezer, J. dissenting) ("Whether the charitable or uncharitable characterization [of physician-assisted suicide] ultimately prevails is a question that must be resolved by the people through deliberative decisionmaking in the voting booth . . . This issue we, the courts, need not—and should not—decide. . . . To declare a constitutional right to physician-assisted suicide would be to impose upon the nation a repeal of local laws."); *id.* at 61 (Fernandez, J., dissenting) ("Like so many other issues, it is one 'for the people to decide.' Our Constitution leaves it to them; it is they and their representatives who must grapple with the riddle and solve it.") (citation omitted); *id.* at 61 (Kleinfeld, J., dissenting) ("The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary. . . . That an issue is important does not mean that the people, through their democratically elected representatives, do not have the power to decide it."). *See also* 1 BRUCE ACKERMAN, WE THE PEOPLE: FOUNDATIONS (1991); CAN. CONST. (Constitution Act, 1982), pt. I (Canadian Charter of Rights and Freedoms) § 33 (containing the *Non-Obstante* Clause that permits legislature to abrogate rights, but only if the legislature explicitly decides to do so).

to tell them whether what they may or may not actually wish to enact is constitutionally permitted.

IV. *Conclusion*

For all of the above reasons, I do not reach the merits in this case—merits that are, as Judge Newman said of those that he also did not reach in *Abele v. Markle*, "of extreme difficulty." 342 F. Supp. at 810. What, after all, are we to make of Margaret Mead's statement, cited in one of the *amicus* briefs, that we should beware of giving those who have the power to heal the right to kill, since anthropologically speaking the distinction between the two is relatively new in our cultures? It is certainly worth pondering. But how does it help us to distinguish between giving doctors the right to remove life support systems and the right of the terminally ill to demand lethal drugs from the same doctors? And how is one to weigh petitioners' claim that if doctors are not allowed to give patients lethal drugs for self-administration, those patients will be forced to commit suicide, legally,

in far more horrendous ways—by hanging, shooting, or gassing themselves? These methods, petitioners assert, are plausibly more dangerous to society and devastating to survivors. But is it really the case that terminally ill patients would take such measures? And which way would it cut, if they did not? These questions, moreover, hardly begin to approach the human tragedies, and the deeply held beliefs, that the issues we would have to decide would require us to explore. No. Unless New York forces us to face such choices head on, by asserting its interest in the prohibitions before us, we should not do so. And this New York has not done.

I would hold that, on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the United States Constitution to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness. I would, however, take no position on whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves. I therefore concur in the result reached by the Court.